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Community Trust and Endowment

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Rural Nursing

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Current Reports on Public Health Nursing

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IN THE WAKE OF THE HURRICANE

It is much too early to give anything like a complete or accurate picture of the effect of the hurricane or of the Red Cross relief work. These rough notes merely give some of the latest data from telegrams and cables. They are necessarily incomplete and subject to revision but sufficient to show that the hurricane left behind it a disaster of great proportions, in some respects even more devastating than the Mississippi Valley flood. For instance, in Porto Rico there are between five and six hundred thousand people absolutely homeless, foodless and destitute, entirely dependent upon the Red Cross for life itself for the next two months. This is the largest number the Red Cross has ever had to care for at any one time, though it does not exceed the total cared for at one time or another during the flood.

The loss of life also has been at least ten times greater. This would not have been true had not the wind scooped the waters of Lake Okeechobee over the dikes flooding the farm lands for miles around, drowning two thousand or more people. The destruction, too, was very thorough. In Palm Beach County it was estimated that 95 per cent of the buildings were damaged; hundreds of them completely destroyed. In one small town on the shore of the lake, only two buildings were left. In Porto Rico over fifty thousand buildings were utterly demolished and a like number damaged.

The Red Cross again is burdened with an enormous relief undertaking. Food alone, sent from San Juan and other coast cities of Porto Rico by Army motor trucks to depots in the interior for distribution in the wrecked areas will cost a quarter of million dollars a week. So scarce is the local supply of food that any interruption of delivery would mean that the storm sufferers would be completely without food. Excessive heat, legions of mosquitoes, telephone and telegraph systems down, no airplanes nor fast trains, movement of personnel and supplies about the island by auto, truck, horseback and foot only, inability to speak the language—these are a few of the minor handicaps the Red Cross workers are facing in operating a disaster relief undertaking which one leading Porto Rican declared to be the biggest business on the island outside the Government itself.

In Porto Rico the health situation is apparently serious but not alarming: 247 were killed, over 5,000 were injured, there is typhoid at some spots and a mild form of influenza is prevalent. According to the latest reports these diseases are neither on the increase nor the decline and the expectation is that they can be held at their present number.

To cope with the situation, Dr. DeKleine, medical officer of the Red Cross, several medical men from the Army and the United States Public Health Service, and 30 Red Cross nurses under the direction of Malinde Havey, chief nurse, and Pansy Besom, assistant, together with 31 Porto Rican nurses, are at work in Porto Rico, coöperating with the Porto Rican health authorities and hospitals. Equipment for two one-thousand-bed hospitals was sent by the Army at an early date. With this equipment, emergency hospitals have been erected at several points and municipal hospitals have had their facilities greatly increased. Inoculations are under way, and the sick and injured are being cared for.

In Florida there were few serious injuries, though many minor ones. The principal task consisted in caring for and protecting the homeless gathered into the refugee camps, caring for the injured and sick, and assisting the State Department of Health with wholesale inoculations. Eighty-five Red Cross nurses were on duty. Health conditions are fast returning to normal. The Disaster Nursing Service there is now in charge of Ruth Mettinger, Nursing Field Representative for Florida and Georgia, with the assistance of Marie Phelan.

ELIZABETH GORDON FOX

During a lull in the Public Health Nursing Section meeting at the American Public Health Association convention in Chicago, there was a general clamor to hear Miss Fox tell of her Florida disaster experiences. Simply and informally she told—

On that September Sunday she was just sitting down to dinner with her family in Washington when a telephone message came asking her to report at Red Cross headquarters. She left at once. At headquarters she found the whole staff on duty, telegraph and messenger boys running in and out, telephones ringing, orders being issued and reports being received from government departments. Continuous reports from the Weather Bureau were followed on a huge wall map of Florida, and as the storm area crept nearer, excitement increased. For the first time in history a disaster was predicted and its course plotted, and the Florida Red Cross chapters prepared themselves. The storm struck. Instantly all communications from the Weather Bureau and all other sources ceased. Florida—which a moment before had been in touch with the outside world by radio, telegraph, telephone and transportation lines—dropped into oblivion. This silence, portending possibilities one could not measure, lasted several hours, while anxiety at headquarters was at its height. Then one message sent out by an amateur radio-broadcaster was picked up by a Navy cruiser and relayed to headquarters. It came from a Red Cross Chapter chairman and said, "Send food, clothes, doctors, nurses, medicines! Send food, clothes, doctors, nurses, medicines!"

Miss Fox started at once for Florida. Her train encountered the storm on its way up the coast and was delayed 15 hours by floods. It was Tuesday night when she reached West Palm Beach. Electric lights were gone, lanterns and flash lights were being substituted. The streets were so littered with debris that the automobile had to be guided through to the hotel. Here the scene resembled an emergency war hospital—the first floor had been given over to dressing rooms, the second to an emergency hospital, the patients on cots. Fortunately, owing to the forewarning most of the people had escaped serious injury, but there were hundreds of minor injuries to be dressed and inoculations to be given. The staff worked 18 hours a day for almost three weeks.

When Miss Fox left the disaster area the situation was well in hand, and reconstruction already begun.

Community Trust and Endowment for Public Health Nursing

By Homer Wickenden
Assistant Director, New York Community Trust

THE accumulation of an endowment fund for a public health nursing organization has with it certain responsibilities that should be neither overlooked nor regarded lightly. They relate on one hand to management of the principal of such funds and on the other to the use of the income from them.

A gift for endowment purposes may take one of several forms; it may be an outright and unrestricted contribution; it may come as a bequest under the donor's last will and testament; or it may come as the proceeds of a life insurance policy in which the organization is named as beneficiary. Frequently, however, sums for the benefit of the association may be payable not to its treasurer, but to a trustee, the income only to be paid by that trustee to the organization. This trustee may be either an individual or a corporation such as a bank or trust company. Such gifts to a trustee are usually spoken of as trust funds.

When the endowment funds are controlled by the finance committee of the nursing association, the committee usually decides or appoints one of its members to decide how the money shall be invested and what securities shall be bought.

But making the initial investments is far from the whole problem—a periodic review of them should be made to see that they continue from time to time to be the best investments for these funds. This is necessary because the value of even the best securities fluctuates and only by a careful study of the market is it possible to secure the maximum income that is consistent with absolute safety of the principal.

TAKING ADVANTAGE OF EXPERT SERVICE

Rather than leave the problem of investment to the finance committee there is an advantage in using a trust company or bank as the trustee, for such a financial institution has experts whose job it is to make a periodic survey of the securities held. Their advice is always available as to whether endowment funds should be invested, for example, in government bonds at 3½ or 4 per cent or in mortgages at 5½ or 6 per cent.

Another advantage of the trust company or bank over an individual as trustee is that unlike the individual, it is a corporation which never goes abroad, never gets sick, and never becomes too busy to look after the interest of its clients.

A trustee, whether an individual or a corporation, may charge a fee for its services, the rates being fixed by law, but the fee is based largely on the amount of income the trust funds yield. So the more income the trustee can produce for the organization, the larger his fee may be. Usually the savings and increased earnings effected by a bank or trust company more than offset the amount of the fee and the organization has the satisfaction of knowing that its endowment fund is being handled by experts.

Although the investment of the principal of such funds is a problem, one might easily think that there are no difficulties in connection with the spending of the income—but unfortunately this is not always true.

If endowment gifts are given outright to the nursing association for any charitable use it deems best, of course no difficulties arise.

RESTRICTED ENDOWMENT FUNDS

If, however, gifts or bequests are made "in trust" for fixed purposes, the organization cannot lawfully divert the principal or income to uses other than those specified. If for example,

under the terms of a will $100,000 were left "in trust" for the maintenance of a public health nurses' home, neither the $100,000 nor its income could ever be used for paying the salaries of visiting nurses, no matter how desirable that might be.

The fact that trust funds for charitable uses may be established "in perpetuity," that is, that they are permitted to go on forever, makes them more difficult to administer, particularly if iron clad restrictions are laid down by the donor for the use of the income. To change such restrictions is usually a difficult and costly, if not impossible, legal task.

The following incident is an illustration:

> Some years ago a lady in New York state built a bell-tower for the church of her native village, and put some books inside the tower to make a library for the village. The tower was so small that two people could not pass each other on its spiral stairs and the aged persons of the village couldn't climb the winding steps at all. When she died she left in trust some shares of stock whose income would buy more books, and some other shares "to keep the . . . tower and bells in good condition." These last were 39 shares of the New Jersey Zinc Company common stock. The World War came. In 1914, the dividends on New Jersey Zinc rose to 50 per cent. In 1915, after paying 50 per cent more, it added a stock dividend of 250 per cent. In 1916, it declared dividends of 76 per cent on the whole of the enlarged capital. The income alone in this year was two and a half times the par value of the original principal. Surplus income, ten times the amount of the par value when the trust was made, piled up unused, though books were bought for the library until "no further purchases could be made on account of want of room in which to keep the same." Finally the trustees resorted to court proceedings in an effort to find some lawful method of using their mounting income to provide more library facilities than the confines of the tower would permit. The words of the will were plain—the library was to be "in that tower." Those directions, the court decided, forbade the use of any separate building. The trustees might remodel the tower to hold more books but excess volumes might not be placed in any other structure!

If a nursing organization ceases to exist, or changes its purpose, the disposition of trust funds held for its special use presents a problem. Under either of these circumstances such a fund might revert to the heirs of the donor, or lie idle.

If public health nursing should at some future date become entirely a tax-supported function and nursing associations as we know them should go out of business, such restricted endowment funds could not be turned over to the city or to another organization.

Or if through the activities of the Grading Committee a number of training schools for nurses are discontinued, those with trust funds and endowments may find themselves involved in a peculiar situation in which the heirs of the donors of these trust funds ask for their return.

HOW THE COMMUNITY TRUST PLAN WORKS

To meet just such difficulties as these, organizations known as community trusts or community foundations have been established. The first community trust was the Cleveland Foundation, organized in 1914, and since that time upwards of 60 cities have established similar agencies.

The essence of the Community Trust plan is this. One or several trust companies or banks agree to receive, hold and faithfully manage as trustee, the principal of sums given in trust for public charitable, educational or benevolent uses. They agree further that they will distribute the income of such funds only under the authorization and guidance of a publicly appointed distribution committee.

Using the New York Community Trust as an illustration, that organization has 22 banks and trust companies which through the adoption of a common resolution and declaration of trust have agreed to serve as trustees for charitable funds. The distribution committee of eleven members is appointed in part by the trustee banks and in part from such public sources as the senior judge of the U. S. Circuit Court of Appeals, the mayor, and the presidents of the Association of the Bar, the Academy of Medicine, the

Chamber of Commerce and the Brooklyn Institute of Arts and Sciences.

Each fund of the Community Trust, whether large or small, is held under the broad terms of this resolution and declaration of trust, by which the distribution committee is authorized to amend the purposes for which funds are established in the event that it becomes impossible, impractical, unwise or unnecessary to carry out literally the wishes expressed by the donor.

This provision keeps such trust funds usefully employed, regardless of how long they exist or how circumstances change.

One of the first funds received by the New York Community Trust, under this plan, was the gift of Mrs. Felix Warburg of $500,000 in memory of her father, Jacob H. Schiff, for the support of the Visiting Nurse Service of Henry Street Settlement.

The deed of trust creating this fund reads in part:

> Believing that the nursing work of said Henry Street Settlement is an important public service, it is anticipated by the founder that at some future time such work will be assumed and performed by the City of New York or other proper governmental agency, in which event and upon assurance satisfactory to the Committee on Distribution, that said service of the Henry Street Settlement is adequately provided for through other agencies, the founder desires that the income from said fund, in accordance with the provisions of said resolutions shall be diverted by said Committee on Distribution to other public charitable or benevolent uses and purposes as provided in said resolutions.

Under this flexible arrangement the principal of the gift is well safeguarded and fifty, one hundred, or two hundred years from now, the income will still be disbursed by the hand of a living and intelligent committee, carrying out as far as possible the desires expressed by Mrs. Warburg.

The services of the New York Community Trust would likewise be available for anyone desiring to create a fund for the National Organization for Public Health Nursing.

The community trust as a repository of the endowment funds for charitable purposes was given the endorsement of the Association of Community Chests and Councils at its conference in Washington in February, 1928. The report of the section of the conference dealing with "Permanent Funds" says:

> Two basic problems were identified as, first, financial responsibility for safeguarding capital and income from the standpoint of investment, and second, social responsibility for directing the use of the income and capital for wise social purposes.
>
> It was agreed that trust companies may in general best be entrusted with the financial responsibility, and that committees of distribution widely representative of community thought may best be entrusted with the social responsibility. . . . For a number of reasons Community Chests were not deemed ideal distributing committees for income on permanent funds. . . . The device of the community trust met with universal approval as an experiment in this field.

The community trusts and foundations of this country have in the few years of their existence been made responsible for more than $15,000,000 in capital funds and during the past three years they have made the following distribution of income:

1925	$441,856
1926	492,420
1927	593,036

In view of the fact that most of the funds coming to community trusts, come through bequests usually not effective until many years after the writing of the donors' wills, the accumulation of funds is somewhat slow. But the amount already in hand is strong evidence of public approval of the plan.

When wills now known to have been written become effective, it is expected that the combined resources of the various community trusts will exceed $100,000,000.

Public health nursing organizations that contemplate the accumulation of endowments will profit by study of the plan and use of the machinery which the community trusts have established for the safeguarding of the principal and the wise social expenditure of the income from permanent funds.

Cereals—Main Stay of a Good Diet

By Williedell Schawe

Assistant, Nutrition Bureau, Association for Improving the Condition of the Poor, New York City

THE normal infant at about six months receives his first taste of cereal gruel or jelly and from then on there is a gradual increase in the daily amount. Wise mothers continue the abundant use of cereals through the growing preschool and school periods, including the adolescent ages. Particularly during the latter period is this apropos when the energy requirements are equivalent to those of a hard working man and woman because of the rapidly growing bodies of these youths.

Cereals have other advantages in the diet. Aside from being a good source of fuel and producers of excellent growth when in combination with other foods, they are also economical. Without them it would be most difficult to keep our food budgets within our means. They are also easy to digest, and as Professor Mary Swartz Rose points out, because of their bland flavor they form a good background for other foods in a meal. Because whole cereal grains are rich in vitamin B, the growth promoting substance so essential for best development in animals and human beings, we are justified still further in giving them such a prominent place in the diet. Likewise, the same vitamin is known to have a stimulating effect upon the appetite which might explain our practical advice to mothers and children that to learn to acquire a taste for foods, particularly cereals, we need only eat a little at a time and gradually increase the amounts. By and by we develop a liking for the food—probably the little vitamin B does the magic trick.

There may be lingering in the minds of some of us the discussion of a few years ago that oatmeal might cause rickets if fed to children. Fortunately we have been encouraged not to be alarmed over the report that caused us so much concern when first announced. It has been pointed out that there cannot be any danger in advocating abundant whole grain cereals in this country where we are particularly careful to include with the cereals other essential foods, such as dairy products, fruits and vegetables, eggs, and in addition cod-liver oil and an abundance of sunshine—all important factors used as our weapon against rachitic developments.

Nurses, nutritionists and social workers are constantly confronted with problems in the homes where parents have neglected to develop in the early periods of their child training the liking for the whole grain cereals. At an older period there is difficulty in acquiring the taste. The fault lies more often with the mother than the child. In the eagerness of the mother to have the child eat cooked breakfast food her attack is sometimes too abrupt. She urges upon him too large servings which produce the effect of forced feeding. Small servings to begin with of well prepared foods, together with not too much concern on the part of the mother, bring about the best results.

The method of cooking is often at fault. Cereals that are watery and gelatinous give that "slick" feeling when eaten that is repulsive to certain sensitive children and even to adults. Oatmeal or wholewheat cooked in a

double-boiler does not require as much water as in the open kettle method, and, carefully stirred with a fork, is a much more palatable product when finished. The partial preparation of some of the cereals also reduces the long hours of cooking. The latter used to receive considerable emphasis and was partly responsible for the omission of cooked cereals by some mothers, who were perhaps none too ambitious.

Relieving Monotony

"Monotonous" is another term sometimes associated with cereals. With the variety on the market this should not become a factor. There are several whole grains, particularly oats and wheat, which are somewhat different in appearance and flavor and yet are practically the same from a nutritional standpoint. It is natural that when one cereal appears on the table seven days out of the week it becomes tiresome and uninteresting. Even the same cereal may be "doctored" so that it seems different. The combination of figs, dates, raisins and prunes with the cereal changes the appearance and likewise adds a new flavor. Cereals served in soups and made the main body of puddings add new interest. Oatmeal soup has become quite popular. The recipe follows:

1½ cups of tomatoes
5 cups water (or soup stock)
½ large onion
1½ teaspoon sugar
¾ of a cup of oatmeal

Boil the liquid; add the rest of the material. Boil together from three-fourths to one hour. For small children this soup may need to be strained.

Children who are old enough may be given the responsibility of buying the cereal, provided they are instructed to get the whole grain. This applies particularly to children who object to cereals in general. In one instance, recently, the youngster selected the most attractive looking box which fortunately contained a good cereal. He was so pleased with his purchase and that it met with his mother's approval, that he has not murmured since when it is served. If all cereal companies made attractive boxes the prices would doubtless increase — a condition we would certainly not like to see since one of the chief attributes of this food is economy.

Cost and Fuel Value

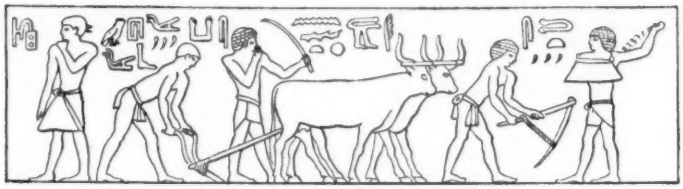
Often the question of ready-to-eat cereals and cereals to be cooked has to be considered. While some few of the ready-to-eat cereals are made from the whole grain, many of them are so light in weight that an abnormal amount would have to be eaten to obtain the same fuel value as one average serving of a cooked cereal. A visit to a chain store and a comparison of prices will be enlightening. A recent investigation of four ready-to-eat cereals showed an average cost of 22 cents per pound, while four cereals to be cooked averaged 12 cents per pound.

The above costs may be applied to the needs of a family of five. Since the cost of gas should be included, an allowance of two cents per hour on an average size burner is estimated at a total cost of 14 cents per week. Finally a rough estimate in savings may be calculated as follows:

5½ lbs. ready to eat cereals at $.22 per lb. = $1.21
5½ lbs. cereals to be cooked at $.12 plus $.14 for gas = $.80
Approximate saving per day, $.06
per week, $.42
per month, $1.80
per year, $21.90 — equivalent to 22% yearly interest on $100.00

The average costs will vary slightly in different cities or localities. However, the trend in prices can always be noted.

In families of limited means or where relief must be administered the provision of generous amounts of whole grain, uncooked cereals means an economical, as well as nourishing food. The essential point, as has been brought out, is the provision of suitable supplements; namely, green vegetables, both raw and cooked, fresh and dried fruits, butter, cream and other fats, a



Plowing and Sowing in the Pyramid Age
The Conquest of Civilization—Breasted

little meat for older children (particularly glandular organs such as liver), eggs and a quart of milk for every child, every day. Add to these cod-liver oil when advisable and always plenty of sunshine. On such a diet as this there is little danger of deficiency in the growth promoting essentials.

THE RURAL COMMUNITY AND TUBERCULOSIS PREVENTION

Having spent most of my time since the World War in close contact with people of the open spaces, I feel that I am fairly familiar with their everyday life and interests. In bringing health propaganda to rural communities, we must remember that the first contact established with them is a visual one. In my case, I approach them in my old high boots, khaki trousers, and an old shirt not yet fit for the rag bag. In the case of the county nurse the plain tailored uniform, to which I am very partial, makes the most favorable impression. It impresses the individual with the idea that here is a worker hard at work putting over a job. It should be worn in attending all daytime duties and meetings.

The farmer is an individual who lives in a little world all his own, and the outsider is looked upon with suspicion. His world revolves around crops, grains, the price of fodder and the price of cattle. To get him interested in the things which we are trying to put across, we must convey to him the feeling that we are interested in his interests and thinking his thoughts. This has been deemed good business in politics.

The subject of tuberculosis is one which is shunned by most people. The farmer is an individual who is quick to make friends, and our first efforts must be toward developing that trait. Once I was working on a sanatorium campaign with a doctor in a rural county. I attended several meetings at which the doctor spoke, and to all intents and purposes he seemed to impress those present with what he had to say. As I sat on the roadside waiting for the hall to clear after the meeting, the comment I heard was " We do not need a city man to come and tell us how to spend money." I will admit that as a *worker* I had the advantage over the doctor. Nevertheless, I believe that the people who live in that community were so impressed by his importance and his good clothes that they lost track of the main issue presented.

One other point I must caution against. In everyday work we use many words which are strange to the farmer. Try to make your speech as plain and simple as possible so that there will be no chance of speaking over the farmer's head. I do not mean to convey the idea that the farmer is illiterate. He is a man who is working hard to earn his living and his work employs him from five in the morning to eight at night. As a result, his whole thought and being is wrapped up in his work. He has not the time nor the interest to search for definitions outside his own technical field. Save his time by omitting medical terms.

In regard to exhibits, a tie-up between the farm and the home is bound to make the farmer stop, look, and listen. Modern farming entails a knowledge of dietetics for cattle and soil conditions for grains, and the comparison between them and the home can be very readily drawn.

JACOB VAN KOOY
Exhibit Department, Wisconsin Anti-Tuberculosis Association

Service Costs and Program Planning

By Emma A. Winslow, Ph.D.
Director of Research, The Commonwealth Fund Child Health Program

IN earlier articles* we have been considering various problems connected with the measurement of nurse-power in the terms of nursing time and volume of service. Especially valuable in program planning, however, is the analysis and evaluation of health work in terms of service cost. What is the cost of conducting the different types of health activities? Which services are relatively expensive and which are relatively inexpensive? If economy has to be considered, how much financial saving will come from the lessening of certain activities? If funds are available for program expansion, how much and what additional work can be inaugurated with surety of sufficient financial support?

All these are exceedingly important questions in the planning and administration of public health nursing, and it would seem that answers should be fairly easily available in the detailed financial and service records now being kept in most nursing organizations. Much progress has been made during recent years in securing uniformity in methods of calculating visit and other unit costs, especially among agencies carrying certain services on a contract basis. As yet, less has been done in developing desirable procedure for the analysis of total expenditures for nursing activities so as to give a complete and accurate picture of relative costs.

Just recently much time has been spent in the Commonwealth Fund child health demonstrations in developing what promised to be the most practicable method of calculating service costs. Summaries of the results of these studies will be included in the published reports on activities and accomplishments in the four demonstration centers.

As the determination of service costs in the demonstrations has necessitated a number of important decisions on policy, the method finally followed and the reasons back of certain decisions are here described in considerable detail with the hope that this experience may be of assistance to nursing administrators and others interested in similar studies elsewhere. So that it will be clear just what type of cost information comes from the demonstration plan of analysis, a number of illustrations with special reference to nursing have been included from the studies of service costs in the five-year demonstration recently completed in Fargo, North Dakota.**

METHOD OF CALCULATION

The purpose of cost studies in the child health demonstrations was primarily to assist in program planning and evaluation. For such use the most satisfactory method, and also the most accurate, seemed to be to place main emphasis upon the detailed analysis of salary costs on the basis of records of time distribution, without attempting under present conditions to include also under the costs of the various services the results of detailed allocations of operating and maintenance expenditures.

Dependence on the analysis of salary costs rather than total costs has certain obvious advantages. Salary rates in public health work are rapidly becom-

* See The Public Health Nurse, October, 1927. The Measurement of Nurse-Power. Also The Public Health Nurse, February, 1928. More About the Measurement of Nurse-Power. By Emma A. Winslow, Ph.D.

** For detailed report on demonstration services in Fargo see Part Three of the Final Report, Serving the Child in Fargo, Bull. No. 9, Child Health Demonstration Committee. Copies available on application to The Commonwealth Fund, Division of Publications, 578 Madison Avenue, New York.

ing standardized so that service costs based on salary only are readily comparable for different communities and for different types of organization. It is a simple matter to allocate salary expenditures by type of service if records of time distribution are being kept periodically or routinely, and great detail can be secured if desired. Unless salary rates are at quite different levels fluctuations in service costs calculated in this way are likely to be in close agreement with actual differences in health service organization.

Operating expenses, however, are likely to vary considerably in different places and in different types of health agencies without relationship to program carried. Rent, heat, light and janitor service are more costly in certain sections of the country than in others. Expenditures for transportation may be quite different if buses or street cars can be used, or if each member of the health staff has to have his or her own automobile. Large organizations are often able to take advantage of lower prices in quantity purchasing and secure various other economies in operation not as easily possible for an organization conducted on a small scale. Even in the same agency, operating expenditures may be relatively high during a certain year when automobile or other expensive equipment has to be replaced, with little or no effect on the volume or extent of the health service being rendered.

There is also a good deal of difference in practice with reference to the completeness with which the various operating costs are included in health expenditures as reported. For instance, if headquarters space is provided in public buildings, as is the case in most official agencies, there may or may not be a charge against the health department for rental and related maintenance costs; in voluntary health agencies, these items of housing expense nearly always form an important part of total operating costs. Certain other items have an unexpected way of appearing and disappearing in lists of health expenditures, especially in organizations with several types of service activities, not because of differences in the expenditures themselves but because of differences in allocation as a general or a departmental expense.

IN DIFFERENT PLACES AND TYPES

Also, as demonstration experience shows, many difficulties are encountered in distributing operating costs relating to nursing among the various types of nursing activity, especially in a generalized program with financial support coming from different sources. With certain expenditures made by the Board of Health, others by the Board of Education and others by voluntary agencies—each one with its own accounting system—differences in current classifications may make almost impossible the later combination of similar items according to a desired plan of cost analysis. Even with expenditure classifications carefully considered in relation to later cost analysis (as was possible in the accounting system for demonstration funds) it was far from easy to determine with reference to certain operating costs how much should be charged against infant and preschool service, school service, tuberculosis care or other phases of nursing activity for which salary costs could be allocated with accuracy and in considerable detail.

For these various reasons the detailed analysis of operating expenses in relation to service costs has not as yet been attempted in the cost studies in the demonstrations. The desirability of such analysis is fully realized, however, and it is hoped that eventually procedures will be developed which will bring the determination of this important phase of service costs within the range of practicable possibility.

THE SUPERVISOR'S SALARY

While the study of salary costs for different health services was relatively simple in comparison with similar study of operating costs, there were a number of important problems to be solved. For instance, should the salary of the nursing supervisor be included with that of the field nurses in

calculating nursing salaries in service costs? The final decision on this point was that the preferable figure for service costs in the demonstration centers was one based primarily on salary costs as paid to field nurses. During the demonstration period much of the time of the nursing supervisor was used for community education and organization rather than for detailed work in the supervision of the field activities of her relatively small staff of well-trained and experienced nurses. In the post-demonstration program in operation in Fargo and being planned for the two southern demonstrations the responsibility for staff supervision is being carried by one of the nurses in addition to her district work, and there is no continued expense for the salary of a full-time nursing supervisor. In the demonstration studies, therefore, the only part of the supervisor's salary included under service costs has been the rather small amount to cover (at the hourly rate paid to staff nurses) the hours which her time records showed were used under emergency conditions for relief service in health centers, schools and field visits.

SALARY COSTS PER FIELD HOUR

How to distribute among the costs for field service the salary costs for time used in travel, office work, and other related activities, was another problem requiring careful study. After much experimentation, it was decided that the simplest method of distribution would be one based on the assumption that about the same salary cost for these related-service activities is required for each of the various types of nursing service. This may not be true in certain instances, as when a particular service requires an unusually large amount of travel or office time. Demonstration experience, however, would seem to indicate that the relative amounts of these related services do not usually vary sufficiently in accordance with type of service to necessitate detailed differentiation in service cost per field hour.

The hour of field time (here defined for staff nurses as time actually used for service in health centers, schools and field visits, exclusive of time used for travel, office work and other related activities) has therefore been used as the unit in the calculations of time and cost for all phases of nursing service in the demonstrations, and each hour of actual service in the field has been assumed to carry with it an unvarying amount of time for related-service activities as determined by local time studies.

Either of two different methods of calculation brought the same results in the determination of salary cost per field hour. If the cost per hour during which the nurse is employed is used, the cost per field hour becomes the cost per hour employed in field service plus the cost per hour employed for the amount of related-service time required per hour of field service. The other method eliminates any use of the cost per hour employed and makes the calculation of salary cost per field hour directly from the data on total salary and number of field hours.

As illustration let us assume:

> A nurse with a salary of $1,800 a year is employed for 2,000 hours a year and her hours for field service amount to 1,000 hours and for related service also to 1,000 hours. Her salary cost per hour employed is $.90 and her salary cost per field hour will be $1.80, whether we count it as $.90 per hour employed for the hour of actual field service plus $.90 for the related time for travel, office, etc., or if we calculate its cost direct by the division of $1,800 by the 1,000 hours of field service.

Because of its greater simplicity the second method has been the one used in the cost studies in the demonstrations.

As indicated by the cost figures for nursing service here presented for Fargo, there is a considerable variety of information which can be drawn from data on salary cost per field hour in combination with certain data on time distribution and on volume of activity. Figures on unit and yearly costs for different types of nursing service seemed to be especially valuable for use in program planning and analysis. Per capita costs in relation to total population also proved of sig-

nificance, both in studying local work and in making comparisons as to the extent and relative cost of health services organized in communities with larger or smaller population. Other calculations, such as:

The cost per individual served
The cost per capita for maternity and infant service in relation to number of births
The cost of certain school services in relation to school population

were found to have less value in studying the community health program as a whole, and to be better adapted for use in studies of costs of special activities.

Salary cost per hour of field service varied in different years from $1.68 to $1.87, being somewhat higher during the earlier years of the demonstration program. For the period as a whole the salary cost per hour was $1.76.

During an eighteen months' period in 1925 and 1926 detailed summaries were made of visit time by type of visit, and periodic checking showed that the averages thus secured were in fairly close agreement with visit time during the earlier and later years of the demonstration.

Applying these averages for visit time to the average salary cost of $1.76 per hour for field service, we find that the salary costs in Fargo for the different types of nursing visits were as follows:

For Health Supervision

Infant	$.41
Preschool	.25
School	.29
Adult	.40
Maternity	
Prenatal	.56
Postnatal	.58
Tuberculosis	.36
Other communicable	.31
Care of sick (non-communicable)	.82

Visits in behalf of patient were relatively long and had a salary cost of $.66 per visit. Visits to cases not found and not taken up were relatively

YEARLY SALARY COST FOR PUBLIC HEALTH NURSING FIELD SERVICE, FARGO, N. D.

	1923	1924	1925	1926	1927
Total salary cost *	$8,923	$11,292	$11,540	$10,943	$10,757
Total hours in field service **	4,767	6,363	6,501	6,394	6,386
Salary cost per hour of field service	$1.87	$1.77	$1.78	$1.71	$1.68
Salary cost for field service hours in					
Health centers	$421	$708	$907	$984	$1,070
Schools	4,757	5,373	5,091	5,179	5,151
Nursing visits: total	3,745	5,211	5,542	4,780	4,536
Maternity	260	529	653	512	421
Health supervision	1,707	2,880	2,954	3,168	3,049
Tuberculosis	142	224	371	282	357
Other communicable	247	217	316	298	204
Care of sick (non-communicable)	1,389	1,361	1,248	520	505

* Includes salary of six staff nurses and also of nursing supervisor for time used in relief work for staff nurses in health centers, schools and field visits.

** Includes only time used in actual service—time for travel, office work and other related activities here excluded.

SALARY COSTS FOR NURSING SERVICE IN FARGO

As shown in the accompanying table, the total salary cost for the six staff nurses in Fargo (including the small amount of salary cost for time used by the nursing supervisor in relief work) was about $11,000 a year from 1924 to 1927, somewhat less in 1923 when the nursing service was still in process of organization. The salary rate for staff nurses throughout the demonstration period was $1,800 a year.

The total hours each nurse was employed averaged about 2,100 per year and of this about 1,050 hours were used for field service in health centers, schools and nursing visits, and about 1,050 hours for travel, office and other related activities, including vacation and sick leave.

short and had an average cost of $.13 per visit.*

Salary cost for nursing assistance at medical examinations of infants and preschool children in health centers averaged $.55 per examination. Similar assistance at school medical examinations, with their shorter average time, cost $.26 per examination.

While unit times and costs for various nursing services did not vary greatly during the demonstration period, there was a considerable amount of difference in certain years in the total costs of the various services, as shown in the accompanying table. The salary cost for nursing time in health centers tended to increase steadily as the program progressed and the salary cost for time for field visits tended to decrease. With routines established for nursing service in schools, the salary cost has remained relatively unchanged during the last years.

If we compare data on relative numbers of different types of nursing visits (as given in Part Three of the final report of the Fargo Demonstration) with data on relative costs, we find that the cost figures in certain instances give a somewhat different, and probably more accurate, picture of program emphasis. For instance:

In 1927 about 5 per cent of total visits in Fargo related to care of the sick; because of the comparatively long time per visit, about 11 per cent of the total cost of nursing visits was devoted to this service. Prenatal and postnatal visits took about 7 per cent of total visits, about 9 per cent of total visit cost. The relatively short visits to school children for health supervision required about 30 per cent of total visits but only about 25 per cent of total cost.

Expressing the yearly cost for nursing salaries in relation to Fargo population, we find that the total cost was about $.44 per capita. Of this, about $.04 was for service in health centers, about $.20 for service in schools and about $.20 for field nursing visits.

As described above, these salary costs for nursing service exclude any salary costs related primarily to nursing supervision or other phases of health department organization and administration; if these had been included, service costs would have been correspondingly increased. Also, in using Fargo figures in comparison with those from other communities, it should be realized that certain parts of the field service by the staff nurses were simplified by the community education and organization work being done by other members of the demonstration staff, and that the salary costs for the various nursing activities probably represent a lower figure than would be possible in communities where less of this supplementary service was available for staff nurses.

During recent years total expenditure for local health services in Fargo (excluding those for the communicable disease hospital) has averaged about $30,000 a year; of this, about $22,000 was used for salaries to the technical staff and about $8,000 for operating expenses including clerical salaries. As already discussed, no attempt has been made in the demonstration studies of service costs to include any detailed allocation of operating expense. If this had been done, the ratio between total salaries and total operating costs in Fargo would seem to indicate that the various service costs calculated with reference to salary only would have been increased by about one-third.

ADVANTAGES AND DISADVANTAGES

The method of cost analysis in use in the child health demonstrations has its advantages and disadvantages. Chief among its advantages would seem to be its relative simplicity. It requires data on salary expenditure—about the easiest kind of cost figure to get on a comparable basis—plus certain data on time distribution plus data on the volume of service activity. The actual making of the cost calculations requires but little time and only the

* In service costs as later calculated these visits in behalf of patients and to cases not found and not taken up have been included under the type of service to which they related, rather than being counted as a special type of service.

simplest sort of mathematical processes. The results have apparently considerable value in program planning, administration and evaluation and can be made easily understandable by lay groups.

The main disadvantage would seem to be the incompleteness of the apparent picture of service costs when the calculations are based on salary only. As already pointed out, this omission in the demonstration cost studies has been a matter of necessity rather than choice, and it is to be hoped that in the near future practicable procedures will be developed through special studies in various organizations so that service costs including both operating expenses and salaries can be made available for use in program evaluations of health services.

CHRISTMAS GIVING

"What shall I do? What shall I do?"
So wailed the P.H. nurse.
"I cannot find, I cannot find,
A gift to fit my purse.

"I've searched the stores, yes, all the stores,
And still I have not found
A gift of worth and dignity
To last the whole year 'round."

This card reproduced in colors will accompany each Christmas gift subscription

Then suddenly and joyfully,
She spied this simple rhyme—
"Oh that's the thing, the magazine!
I hope my check's in time."

Her friend was pleased, Oh very pleased
With one whole year's subscription.
This magazine as a Christmas gift—
It beggars all description!

We have a list of interested nurses in foreign countries who will not see the magazine unless we make it possible for them. The Christmas season would surely be appropriate for such an expression of international good will. Have all your friends the pleasure of receiving the magazine each month? If so, why not arrange to extend your Christmas giving to include one or more foreign nurses? The name of the nurse selected to receive your gift will be sent to you if you wish.

Yearly subscription, if sent to non-members of the N.O.P.H.N., $3.00; to members, $2.00. Canadian and foreign postage, 50 cents extra.

Rural Nursing *

By Helen S. Hartley
San Joaquin Local Health District, Stockton, California

WHAT is rural nursing? For the purpose of this paper I will remind you that rural nursing is a service given to people who are located far from or, if near, not eligible to the benefits of, organized health and welfare service given the larger cities of their county or state. The service may, and does, vary according to the needs of the people. Perhaps some of these variations are best illustrated by two reports.

1916

The first report was written in 1916 by a nurse financed by the penny Christmas seal, working under the auspices of the county board of supervisors. It is a detailed record of rural school inspection of some 3,000 children; the correction or treatment of some 500 remediable defects; and the organization of health leagues among school children. Considering some of the meager reports submitted in the early day of rural nursing, it is a masterpiece and still holds one's attention for its definite presentation of the problem approached. There were parents who did not know their children's need, or knowing, required help to secure treatment. There were school children eager to learn and do—and here was a leader to aid the teachers in health teaching. Standing out in that report is the fact that although private funds financed the work, from the very beginning it was placed under the supervision of the county board of supervisors and a definite responsibility was laid upon public fund support.

1928

The second report bears a date in 1928 and is a record of the work of one rural nurse which is a part of a county-wide health organization supported wholly by tax funds. There is a full-time county health officer who makes every public health problem a matter for public health education, and public health education a personal education for the people who contribute the funds.

This nurse has an office equipped for work and her report includes reference to almost every phase of present day health work. There are field work items and office activities, for she keeps regular office hours, the time for which has not varied in two or more years. The people have learned her schedule and they come there for much advice that many a rural nurse has travelled far and worked late to give—with less assurance that that advice was desired. There are well-baby, pre-school and school child conference days at the office when the parents come from all the country around to hear what the physician may advise regarding the health and growth of their children. Incidentally they learn other things, too, about health conditions. There are regular hours for immunization when children are brought by parents (or bearing a written request from them) for immunization against smallpox, diphtheria, typhoid or pertussis. Such office service has been given to as many as 245 persons in one month by one nurse.

In addition, there is a monthly mileage record of about 1,000 miles to carry on field work regarding pre-natal and infant welfare or tuberculosis problems; getting an orthopedic child under treatment and watching his home progress; arranging for malnourished children to go to the preventorium seventy miles away, or for someone

* Given at the twenty-fourth Annual meeting of the National Tuberculosis Association, Portland, Oregon, June, 1928.

else to go to the hospital; supervising health of children being boarded in homes by state or county funds; and acting as regular school nurse for about 1,200 school children. This nurse also supervises homes where communicable disease exists, making the placing and removal of the quarantine placard an opportunity for instruction, which in most cases brings the family back to the organization for more information.

She has led parent-teacher associations to help their community health cause by motor corps work; the county welfare department to choose a working volunteer welfare committee — and she herself uses that committee. The superintendent of schools was glad to assign to teachers weighing and measuring of school children as a part of the school health work, and the teachers are using health pamphlets and bulletins she distributes. As a health worker in schools, she is a member of the teachers association. There have been Americanization classes and parent-teacher study groups which have led to the desire for a regularly organized extension course in "parent education." There are other activities mentioned, but these are sufficient to indicate a definite working spirit of service to the people between all service groups of the community. One wonders how one nurse can do so much until it is recalled that she is a part of a county-wide organization.

The nurse's identity in that community is not only that of an individual, but as a representative of the entire organization, she has gained the confidence of the people. When her services are discontinued, the people have confidence that the work will go on uninterrupted.

PROGRESS DURING THE INTERIM

The first report is of a high grade work written at a period when we still were getting disease under treatment. The second is based on family and community service. In 1916 there were comparatively few ardent workers who were willing to believe that hunting down tuberculosis could become a part of general public health nursing service. It is true that it could not if it is the *disease* that is being treated. If one serves the people in family units it will be found that many times the disease or defect which first calls for attention is far from the most important need in that family life.

MEASURING RURAL NURSING

Although rural nursing was, in the beginning, patterned after similar work done in cities, it has gone far afield from those first beginnings. There is no set standard by which we can measure rural nursing as such throughout the country. That of the East differs mostly in inconsequential detail from that of the South and West. Of course, it is necessary to serve the particular need of each locality.

Because in most instances the rural nurse began and is still laying the foundation of health organization in a county with only long distance supervision, she is found working under the auspices of the county board of supervisors, a deputy to the county superintendent of schools, a deputy to a part-time county health officer, a deputy to the chief of police who holds the title of health officer, and some serve under the auspices of an organized health association of lay workers.

We have long been told a servant cannot serve two masters. There are rural nurses serving more than two— for some are working for school districts, each paying part of her salary and desiring all of her time; others are working under a combined fund from two private organizations or public and private funds.

These nurses are also doing needed work that, because of local pressure, must be done by the nurse. We find them doing specialized school nursing, or looking up certain diseases, such as tuberculosis, heart, etc. Some are being forced into looking after communicable disease along with the rest. These rural workers also act as probation officers, relief givers, truancy or attendance officers, health education teachers, and are giving first aid for

minor cuts, scratches and bruises such as should be given by a parent in the home or a teacher in the school. Many splendid nurses have been less successful because they were forced to be executive, administrator and staff worker, publicity agent, promoter, organizer, and last but not least, financier.

It seems very evident that we have got beyond the point of general admiration for the rural nurse as an individual holding the center of the stage in rural health work. Is it not time to measure health work not by the number and personal popularity of nurses in the field, but by the functioning organization and its actual accomplishments? Let us get the community organization with its constructive program before the footlights. Hasten the day when all private health associations are using good business principles in studying their county health resources; planning with the people for more effective health work through efficient health organization; and finally securing public and official support. Only then can we hope to keep the nurse in the rural field unhampered by an endless chain of uncorrelated details that are of less importance than the purpose for which she is being trained, and place her in her proper relationship to the rest of the public health program.

NOTES FROM MEETING OF INDUSTRIAL NURSES, SARATOGA, N. Y., JUNE, 1928

The industrial nurses of New York State were invited to meet during the conference of Health Officers and Public Health Nurses held in June, 1928. Miss J. R. Baner sends us these notes:

The meeting was addressed by Dr. C. T. Graham-Rogers, Assistant Director of the Bureau of Industrial Hygiene of the Department of Labor of New York, who said in part:

In 1907 New York first introduced industrial hygiene into the United States. Beginning with 1909 other states followed and at present industrial hygiene has a distinct place in the program of each and all of the states.

It is not good judgment to call accidents injuries. They should be called untoward happenings. What are usually called injuries should be designated traumatic accidents or traumatic hazards and what are now named industrial diseases should be named health accidents or health hazards.

The industrial nurse should know the hazards in connection with the various types of machines and equipment used by the different workers in regard to the cases which come to her care. For instance a lattice guard might cause headaches when one having only cross sections far enough apart to save the eyes would be as safe to use. Work in a dark part of a room would go more quickly if white aprons and caps which would reflect light were supplied.

In her work of cutting down accident rates the nurse should not make the mistake of being too sympathetic; she should make clear to the worker when he is at fault and why; in 75 per cent of cases the worker is at fault. The nurse can teach the danger of loose sleeves, hair and garments, old shoes, etc. She can teach the men to keep their skin clean by using cold cream before starting on extra dirty work and to use cream again after work instead of benzine and grease solvents that irritate and abrade the skin, leaving a chance for boils and carbuncles. Following the cream with plenty of soap and water will complete the cleaning up.

The safety committee is another place where the nurse proves the value and economy of her service. She should be a member of this committee and by watching for the hazards and studying means to lessen or overcome them she will be better equipped for her regular duties.

Nurse Anne's Thanksgiving

By Eunie B. Willis
Red Cross Nurse, Boone County, Kentucky

One of the Stories Submitted in the Short Story Contest

ANNE CHANDLER, a county Red Cross nurse, in one of the northern counties of Kentucky, a section termed by the native northern Kentuckian as the "high hill country," came into her office after a very busy November day. Anne had looked forward to this Thanksgiving time with great anticipation. There was the Methodist Bazaar. She would drop in and see what success the ladies had had in selling their fancy work, cakes and candies. For had she not spent several evenings making things for their sale? She was curious to know if her contributions were pleasing to the visitors and had met with ready sale. Then too, in the evening there was to be the County High School play, given in the new town auditorium, the first public occasion held since its dedication. Then Thanksgiving dinner was to be eaten with a dear friend, after the service of gratitude for all these blessings in the little country church where she worshipped. Anne was of sincere social nature, filling her place in her community as an individual, helping to further its projects and partaking of its benefits and pleasures.

She had just put aside her coat and hat and seated herself for a half hour of record work when the telephone rang. Anne thought, "I guess it's another invitation for dinner tomorrow." She had declined three already. She called her cheery "Hello," just ready to say next, "I'm dreadfully sorry. My day is already promised." But no, this was a summons to a home of sickness. "Nurse, old Miss Sophy Armstrong up on Big Bone Creek is dreadfully ill. You know she is far from any doctor, and the road is so terrible that the doctor we sent for says he cannot possibly come. He is old, to be riding horseback all the way to her home. Nobody's there but Miss Sophy's sister, Miss 'Teenie.' Say Nurse, won't you come? Miss Teenie walked two miles to tell an old negro woman to come to my house and ask

The Old Log Home

me to call you. If you will come here Bob will hitch up the roadwagon. He knows the road and will carry you up the hill."

Without hestitation, she said, "Yes, I shall start immediately." She knew she could not drop in at the Bazaar, nor go to the school play, but maybe she could go to church and to her friend's home on the morrow.

As she drove her Ford along the country road in the fast falling November twilight she mused over how little hurt comes with disappointment when there is a call of real need. "I had my vacation so full I was just ready to refuse any more plans, and here I am making room in those arrangements to spend a whole night forty miles distant."

It was nightfall when she reached the home of Bob Collins at the foot of Big Bone Hill, but Bob was all ready with team hitched to wagon, and a good quantity of hay in the wagon bed. She stored her Ford in his shed, climbed over the high wagonside and sank down into the hay. Bob carried a lantern in one hand and drove the team with the other. His wife ran after them as they started, calling to them to wait a moment she wanted to send Miss Sophy and Miss Teenie a piece of the pig Bob had butchered that day. Fresh pig is part of a Kentucky Thanksgiving dinner—a sort of complement to the turkey.

The road was some four miles along a creek which they crossed and recrossed on the way up the ravine to the old Armstrong home where these two "old maids" as Bob called them, lived. The Armstrongs, he told her, had owned this piece of rough and rugged land ever since the first settlers had come there. It had been handed down several generations, but now they were "mighty pore" and the neighbors had just carried them in provisions for the winter and had sawed up wood for their use. Bob was garrulous as usual, and Anne often wondered after that ride if the horses were not divinely guided over the steep rocky roads and "sidling" places when it seemed that surely they would turn over.

At last they came to the crude old-fashioned home. Miss Teenie met them at the stile—a dear old bent figure with snow white hair. She held her kerosene lantern high for "Nurse" to see her way and Anne noted that all one side of her face was bruised. Yes, Miss Teenie said, she had been chopping wood just previous to the neighbors' wood cutting in behalf of their winter fuel supply and a stick had "jumped up and kicked her in the face." But she was all right now. First "Nurse" must have supper—fine milk, rabbit pie, and choice preserves—and Anne remembered she was ready to eat.

Everything was immaculately clean in the old log cabin, which consisted of three rooms downstairs with long porches on both sides and doors opening out of the rooms onto these porches, but no openings from room to room. Over these rooms a half story or loft, reached by climbing a ladder on the side of the wall, a typical early settler's home. Anne glanced about the room as she ate and noted the tall mantel over the big fireplace and the iron kettle hanging over the coals singing a welcome to her. Then her eyes caught sight of the two old spinning wheels, one on either side of the fireplace. She exclaimed with delight, "Miss Teenie, you are rich in possessing these heirlooms. I love antiques and I've always wanted a spinning wheel." Miss Teenie was loquacious about the spinning wheels, telling how many years they had belonged in the family, how one was Sophy's and one was hers. Then remembering the business at hand she said, "Now, if you have finished eating, we'll go see Sophy. You know, I couldn't get a doctor to come here, so you please doctor her the best you can." How often Anne had explained to these isolated people that she was just a nurse and could not "doctor folks" when they expected her to carry in her nurse's bag a whole drug store and in herself the ability to

diagnose and prescribe a cure for all ills.

Miss Teenie continued, "Now Sophy is awful sick and she is my own sister, and I love her. But Sophy is stubborn. To-day when I told her I would send for the nurse she vowed that she didn't want any nurse, said that Ma lived and died without a nurse. So I sent for you without her knowing about it. Be careful how you 'go at her.' If she takes to you it will be different from her generally, but I hope she does for I feel better to have you see her."

Miss Teenie related all she had tried to do for her sister, several years her senior, and how distressed she was over her now, and Anne's heart went out to her. She determined to relieve her of her sister's care that night and see that she rested. So with a silent petition to God, as she followed Miss Teenie the length of the rough porch to Miss Sophy's room, that he would endow her with just the right manner of going "at her," she stepped into the presence of her patient, and was announced by Miss Teenie.

"There, Sophy, you wanted a doctor. He couldn't come but Miss Chandler can do just about all he can, and here she is." The old negro woman who acted as messenger for them to summon Anne sat by the chimney corner, and chimed in: "Law, Miss Sophy, Miss Chandler can do anything for you. She's de Red Cross you know."

Very feebly Miss Sophy murmured, "Well, let her do it." And Anne thought, "It was not given me to go 'at her.' God endowed Miss Teenie and the old negress with the ability to put me 'at her' right." During the long night she thought how the instance was typical of all public health work. The nurse can do very little unless the people provide the right attitude of mind and heart.

On examination of the patient Anne found that the heart was slow and irregular and her condition very poor. The sentence she uttered consenting to let the nurse do what she could was the last she ever uttered. Soon she went into the coma preceding death, and so she slept through the night. As for Miss Teenie she climbed the ladder to the loft overhead and slept the first uninterrupted sleep she had had for many weeks, fully assured that the nurse would care for her sister.

At breakfast the next morning Miss Teenie filled with gratitude for Miss Chandler's coming, said, "I want to give you one of my spinning wheels. Which one would you like?" In great delight Anne told her preference and Miss Teenie said, "Well, that one belongs to Sophy, but if anything happens to her and I am afraid it's going to happen, I will give you that one. But if I gave it to you and she got well, then she would be awful mad at me." Anne put her arm about dear Miss Teenie and told her that much as she appreciated the gift she would not accept it at the cost of family peace.

Just at noon time Miss Sophy's spirit took its flight. The old negro woman made her way down to Bob Collins' to have the undertaker called, and as Anne prepared the body for burial, Miss Teenie came to her elbow, and said; "What would I have done if you had not come?" Then she added in a whisper, "Nurse, the spinning wheel is yours now." Grief and gratitude expressed in one sentence.

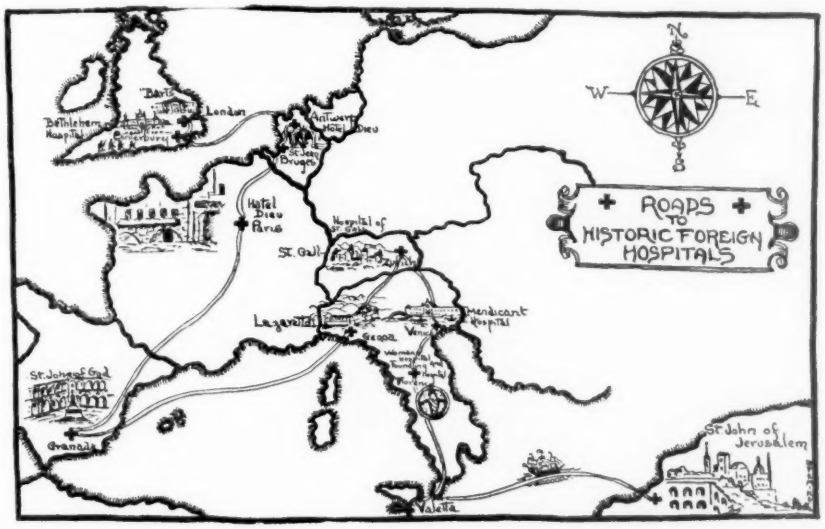
During the morning a drizzling rain had begun to fall and by the time the undertaker arrived it was raining hard. He had been brought by Bob Collins in his wagon just as Anne had been brought the previous night. And since the creeks were rising rapidly and in that season of the year they remain ofttimes so high for weeks that they cannot be forded, both Mr. Gibson the undertaker, and Bob insisted that they immediately carry the body of Miss Sophy down to Bob's to await the funeral and burial. The decision was quickly made since the creeks were rising so swiftly.

Anne, Mr. Gibson, and Bob carried the body out and lifted it into the wagon and Anne sat on the hay and steadied the body in the rough ride. Miss Teenie came out with a basket on

her arm. As she handed it up to Mr. Gibson dishes rattled and he said: "If you have dishes in this basket they will all be broken before we get to the foot of the hill." Miss Teenie said, "I'll hold them. It's just some victuals I'm taking to Sarah Collins." Even in her hour of bereavement going to a neighbor's did not license her to go empty handed. Such was the custom of that locality.

It was late when Anne Chandler reached her home that night and before her cosy grate fire thought over the happenings of the last twenty-four hours. She had not been to church that Thanksgiving morn. She had not dined with her especial friend. "Well," she thought, "I forgot dinner entirely, forgot I had not had dinner. But in all my lifetime I can recall no other Thanksgiving day which at its close has brought my blessings to me so plainly as this one. The home I was in helps me to appreciate the hardships my forefathers endured to further civilization for me. I saw devotion, simplicity, generosity, and love in Miss Teenie's character. This *is* the best Thanksgiving I ever had. It was the real thing. Everyone I saw today was giving. Miss Teenie gave of all she had. Mr. Gibson gave his services gladly for he told me he would not charge one cent. The old negress gave her time and energy. Bob Collins gave his wagon, team and services, and lots of talk. And I, yes, I was able to give help, and everyone was thankful too."

A map reproduced from the 1929 Calendar of the National League of Nursing Education to lure you to the historic hospitals of Europe pictured in the Calendar. The Calendar may be purchased for $1.00 at headquarters, 370 Seventh Avenue, New York City.



The building of community attitudes is both the privilege and responsibility of any social worker, especially of the public health nurse. The trained worker comes and goes, but the community remains. The attitude of the community towards your work is the measure of your success.

Saidie Orr-Dunbar
Chairman of the Department of Public Welfare
of the General Federation of Women's Clubs

Tuberculosis Among School Children in Philadelphia*

Suggestions Concerning Care and Prevention

By Dr. Eugene L. Opie
Professor of Pathology, University of Pennsylvania

THE Henry Phipps Institute has been engaged in a study of the distribution and transmission of tuberculous infections in schools.** Tuberculosis recognized by the customary methods is associated with certain physical signs, loss of weight, fever and other symptoms. The method of school inspection usually employed is a very effective means of discovering these cases of clinical tuberculosis and the children are removed from the schools and put under conditions favorable to the arrest of their disease.

There is, however, another large group of children with advanced tuberculous infection that presents greater difficulties to the medical examiner. It has long been known that a large number of children acquire tuberculous infection who are nevertheless in apparent good health. There is no loss of weight, none of the signs of tuberculosis and no fever. The majority of them are in good health, will always remain in good health, and require no consideration. The rest, however, have advanced infections that will, in a considerable proportion of instances, become clinical tuberculosis.

The study has shown that we can determine what children have infections of this type so that we can put them under conditions that will prevent further progress of the disease. The means of recognizing such infections are chiefly the tuberculin reaction and radiological examination, always in conjunction with a careful physical examination and record of all the pertinent clinical history.

For some time Dr. McPhedran and the writer have been engaged in a study of the spread of tuberculosis in families exposed to open tuberculosis, families that is, in which some member has tuberculosis with tubercle bacilli in the sputum. Of the children of these families, 80 per cent show infection by the tuberculin test before the fifth year, at an age when the tuberculin reaction is found in only a relatively small proportion of all children, approximately 20 per cent. When we followed a group of children thus exposed to open tuberculosis we found that at least one in ten developed clinical tuberculosis. In children in whose families there was tuberculosis without tubercle bacilli in the sputum the number of infections was far smaller.

The number of tuberculin-positive children in Philadelphia is approximately equal to that found in other large cities of Europe and this country. Of children between five and nine years of age 54 per cent react to tuberculin; of those from ten to fourteen years, 77 per cent. In most instances these reactions are caused by minor infections and require no particular consideration. We have examined 2,500 children in the schools and of these 820 have been given radiological examination. We have found approximately 94 individuals with advanced infections: tracheo-bronchial tuberculosis, infiltrations referable to tuberculosis in young children and latent apical disease. We have found few instances of advanced clinical tuberculosis because these are in large part eliminated by the usual methods of school inspection.

The open-air tuberculosis classes of Philadelphia give instruction to children with tuberculosis in open-window rooms. Children are given rest periods during the day, studies and exercises are restricted and a lunch of varied food is provided. These classes are an

* Abstracts from paper read before the Philadelphia Tuberculosis Conference on November 15, 1927.

** Aided by a fund appropriated by the Metropolitan Life Insurance Company.

excellent aid in the control of tuberculosis provided we can select and put into them suitable children. The ordinary methods of physical examination do not suffice. It is widely recognized that children who have tuberculosis so advanced that it produces constitutional symptoms should be taken away from the school, and receive treatment in a sanatorium until their disease is arrested.

Underweight is often used as a criterion for the recognition of tuberculosis, especially when there is some elevation of temperature. Most of the children selected in this way have no tuberculosis and do not react to the tuberculin test. They may have some other chronic infection. Dr. Hetherington has found that there is no noteworthy loss of weight even though there is advanced latent disease. What is most needed is a plan for discovering among the great number of school children the relatively small number who have grave latent tuberculosis. They should be put in open-air classes before their general health is impaired.

Examination of children who apply to the Henry Phipps Institute has shown that a very large part of those who develop the disease are from families in which some member suffers with open tuberculosis. Examination of the children of these contact families by tuberculin tests and radiological examinations discloses many children who have advanced latent infection. During four years a considerable part of these latent infections have become evident disease. Examination of children exposed to contact with open tuberculosis furnishes a practical means for discovering most of the severe latent infections that will become manifest. Thus those children will be selected who can be treated with benefit in open-air classes.

The conduct of the open-air schools requires, I believe, some modification. The existing law requires that children with clinically manifest pulmonary tuberculosis shall be removed from the school classes and this procedure is in accord with prevailing medical practice. The open-air classes should be reserved for children with tuberculous infection that has not caused constitutional disturbance. These children eliminate no tubercle bacilli and are not a source of danger to those about them.

One of the chief difficulties in the conduct of these classes has been their maintenance in separate buildings. Should they be conducted in the same buildings with other classes they would not be dangerous to other pupils. It should be clearly recognized that in the absence of special classes for children with advanced latent infection these children will remain in the ordinary school classes in immediate contact with other children.

There is one more point that I think should be emphasized. Special classes or a special health program for pupils with advanced latent tuberculosis should be available for older as well as for younger children. Adolescence is a critical period for children exposed to tuberculosis and a large part of the tuberculosis which makes its appearance in early adult life has begun its development during the adolescent period of school life. High schools should provide a special regime for such children.

Drawn by a French artist for the French Mission of the Rockefeller Foundation—1919

Protection of Children in the Motion Picture Industry

By Dorothy Deming

THE motion picture industry is claimed to be the second largest in our country. One needs only to recall a few recent photo plays to realize that child actors—anywhere from one year up—are taking part in their production. The most familiar example of this is perhaps the group known as "Our Gang" in which nearly the whole comic cast is composed of children. No public health nurse can see their comedies without a thought for the well-being of the actors and a mental question as to their daily routine, aside from the astonishing antics they picture for public amusement. The fat boy is awfully funny, but should he be so awfully fat? Farina is a great favorite with the audience, but "she" looks undernourished. In the states in which the industry is most flourishing it is not uncommon for the public health nurse to find that the employment of children in the movies is the means of livelihood for a family. School nurses note unexpected absences of certain gifted children from school. They have gone "into the movies." Once in the movies how are the health and education of the children safeguarded? Is there exploitation, or is this a legitimate occupation for them, harmless to body and soul?

EMPLOYMENT OF CHILDREN

Very little detailed information is available on this subject in this country. The U. S. Bureau of the Census during its 1923 Census of Manufacturers obtained certain data in regard to the establishments engaged in the production of motion pictures, but these do not cover statistics as to the number of children employed or the conditions under which they work. Of the 97 establishments reporting, practically half—48—were located in California. The remaining 49 were located as follows: New York—16, New Jersey—8, Illinois—7, Pennsylvania—5, Michigan—3, and 10 scattered in 7 other states.

In California, the leading state, the state child labor law contains a specific provision requiring permits for the employment of children in this industry. A description of the method used in the enforcement of this law in and near the city of Los Angeles—where a very large number of the California establishments are located—is given below.

Of the other states mentioned above—New York, New Jersey, Illinois, Pennsylvania, and Michigan—only New York has a specific legal provision applying to children in this industry—this also requiring the issuance of permits to children for such work.

For New Jersey, the State Department of Labor reports that the state child labor law applies to the making of motion picture films in the same way as to children in industrial establishments in general. This law fixes a 14-year minimum age and provides a maximum 8-hour day and 48-hour week, and prohibits night work, for children under 16. In Illinois, Michigan, and Pennsylvania, the child labor laws applicable to employment in general, or to work in factories, would apparently apply to children in this industry. Their standards are briefly:

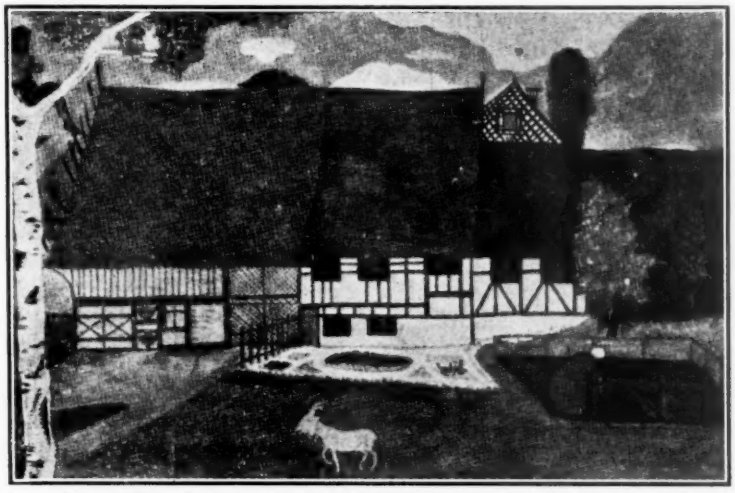
Illinois—Minimum age 14; maximum 8 hour day and 48 hour week for children under 16; night work prohibited for children under 16 between 7 p.m. and 7 a.m.

Michigan—Minimum age 15 for work during school hours; 14 for work outside school hours; maximum hours for boys under 18 and all females, 10 per day and 54 per week; night work prohibited between 6 p.m. and 6 a.m. for boys under 16 and girls under 18.

Pennsylvania—Minimum age 14; maximum hours for children under 16, 9 per day and 51 per week; night work prohibited for children under 16 between 8 p.m. and 6 a.m.

THE CALIFORNIA PLAN

California has the greatest problem and has gone further than other states in its solution. A Central Casting Corporation — a free employment bureau—is maintained by the members of the Association of Motion Picture Producers, and through this bureau at least 95 per cent of all placements of women and children are made. It trols the number of teachers or welfare workers which must be supplied by the studios; and has the power to provide special safeguards wherever the conditions of employment warrant it. The permit only grants the privilege to children to work until 5 P.M. The state law will permit them to work until 10 P.M. provided the entire day does not constitute more than eight hours.



Home Sweet Home—Drawing by Swiss boy of 13 (Revue Internationale de l'Enfant)

Pictorially movie children must be seen in their "medium." Here is another phase of children's art.

represents, therefore, the conditions throughout the industry.

During the year 1927, 1429 children worked one day or more. Of these, 680 were girls and 749 were boys; 30.7 per cent of the total number of children worked only one day in the entire year; 54.5 of the whole group worked three days or less; and 77.4 per cent worked ten days or less during the year. The average daily placement of minors for 1927 was 33. This report covers all minors between the age of six months and eighteen years.

The children employed in the motion picture industry are accepted only after working permits have been issued through the Compulsory Education Department of the Los Angeles Public School System. This permit is issued after the child has been examined by the doctors of the school department, and re-examination is required every quarter. This department also con-

Formerly in communities where schooling had not been specially provided, there was a lack of coördination with the public school work which was detrimental to the class room work. Attendance was irregular, the child was subject to call for acting at any time, thus keeping him under a mental strain and excitement. School attainment is 17 per cent above the average in this group of working children.

Several of the studios, at the suggestion of the Department, have established child welfare headquarters and schools where children are cared for. Small children are seldom, if ever, used more than one hour of the working day. Children under four years have sometimes been used in pictures showing nurseries and similar scenes. The rule in such matters is that children must be carried from their homes,

accompanied by their mothers or nurses, by the companies employing them and may not be used more than one-half day. If in the production of the picture children are required for both forenoon and afternoon, they can work but one half day, necessitating the use of different children. The Supervisor of Professional Children's Interests is paid by the public schools. She coördinates her work carefully with welfare agencies and other persons in a position to help to establish the very best supervisory procedures. Children are not permitted to work unless a physician is available. There is also a nurse on the lot, but not necessarily on the set. Lunches are furnished as prescribed by the Department through the health department of the schools. Comfortable chairs are provided for the mothers who must always accompany young children.

Last year a number of permits were conditioned. Children were required to have certain physical treatments before permits could be issued. These children are examined quarterly, and if any of them show any physical ill-effects, whether due to work in the pictures or from some other cause, permits are revoked until all impediments are removed. The department reports a total of 2,035 children working during the year 1926–27 a total of 8,888 days. The minimum wage for the men and women in the industry is $3.00 per day. For the children it is $5.00. If children leave the city to go to other communities within the state, the mother and the welfare worker are always provided for by the companies.

The Los Angeles system is considered satisfactory, and the National League of Compulsory Education Officials has gone on record as approving it as a model for other industries and local boards of education to copy.

INDUSTRIAL HAZARDS

Unfortunately we have no record of how many other industries have followed California's lead, nor any exact knowledge of the conditions of work. As the National Child Welfare Committee states: "The fact that the labor of these children is in a large measure outside of the law is a cause for apprehension." One cannot help but wonder about the impression on the children. They intermingle, perforce, with adults of all types. They are thrown into an adult world "where they hear and see things which make them oversophisticated, worldly wise, or bold." It is a world of make-believe, a transient purposeless world—cities are built and torn down, the appearance of solid masonry is given by the dab of a brush, even the attitudes—loves, hates and fears of individuals—are make believe. A child's judgment must be super-strong not to be warped, his mind super-keen not to be misled by false pretenses.

In addition there is the very real danger of damage to young eyes working in the glaring special lights, the confusion and interruption to school work, for the school must be near the set—the employment even for short periods of very young children, and the exploitation of the abnormal in face or figure. It is little wonder that industries and departments of education are striving to alleviate some of the conditions under which the children work, and it is to be hoped more will follow the example in Los Angeles. Conditions in other states are still far from desirable.

How important is the question of children *attending* the "movies"? Rather so, because of the enormous number attending. In Los Angeles it was found that 60,000 children under the age of 12 were going to the picture shows every week, and in a large group of school children in Kansas, a typically rural state, nearly half of the 8-year-old children and two-thirds of the 14-year-olds went once a week or oftener. These facts indicate the need for regulating indiscriminate attendance by children, for higher standards in the matter of pictures on the part of parents and the general public, and for the cessation of the habit of parking unattended children at the moving-picture theaters, which some parents seem to find an easy way to assure themselves an evening for their own amusement purposes free from responsibility for their offspring.—*U. S. Children's Bureau.*

Current Reports on Public Health Nursing

Recommendations and Suggestions of the Committee on Records

National Organization for Public Health Nursing, Inc.
Prepared by Louise M. Tattershall, Statistician

CURRENT reports should furnish data for an accounting of work done and results accomplished over definite periods of time and also give a picture of the character of the work. There should be both narrative and statistical reports. Formal reports are usually made only monthly and yearly and should include both a narrative and a statistical statement.

The monthly formal report is an administrative report and for effectiveness should include only such items as show the current progress of the work of the agency. The yearly formal report not only summarizes the volume of the work done throughout the year, but should appraise and evaluate it. The detailed information reported for the year should be analyzed and compiled in various ways to bring out facts of value to administrative and organization problems of the agency.

The details for statistical reports are compiled daily and monthly, and in the case of certain items, yearly. What details are to be reported daily and monthly, how much summarizing is done monthly as well as yearly, will be determined by the needs of the agency. It is not necessary to repeat the same details concerning the work each year, but certain details may be studied one year and other phases the following year.

Daily reporting is of primary importance as it is the basis for the monthly and yearly reports. Monthly reporting will be a summarizing of items reported daily, and of other details. Yearly reporting should be an analytical summary of the reports for the months and of other items which can be compiled but yearly.

The narrative report should include an interpretation of the statistical report, accounts of new or interesting pieces of work which are being carried on, plans for future development of the work and any other items of special interest.

In addition to routine reports it may be advisable to make periodic or special studies in relation to the solution of certain administrative or organization problems.

For the purpose of making up the statistical report, agencies doing public health nursing may be classified according to the chief emphasis of their nursing programs as:

Agencies having a maternity and morbidity (care of the sick) service.
Agencies having health supervision or communicable disease control or school nursing service.
Agencies which combine all or part of one and two.

The reports of these different types of agencies will vary in detail but they may follow the same general plan. It is assumed that agencies will only take into consideration such of the recommendations and suggestions which follow as apply to their particular program. It is also recognized that some agencies wishing for greater detail than is suggested, will want to add to items listed.

RECOMMENDATIONS AND SUGGESTIONS FOR STATISTICAL REPORT

Suggested definitions of certain terms to make for uniform reporting—

A year shall be the period for a complete report on routine activities, and all reporting shall be made on the basis of a current year.

Staff activities shall include:

Visits
Conferences and clinics
School service
Educational activities
Organization activities
Other activities

VISITS

Field visits refers to and may include any, or all, of the types of service which a nurse may perform in behalf of a patient outside the clinic or her office, such as:

Observation and investigation.
Visits of instruction and demonstrations.
Visits where bedside nursing is performed.
Visits of a social service nature which are necessary in behalf of a case.
Also includes visits to patients not found, not home, and not taken up.*

Office visits are visits of individuals to office, at which time a definite service is rendered to the individual and an entry is made on individual's case record or special report.

The only visits to be counted are those for which an entry has been made on an individual's case record or special report.

All visits are to be counted according to the number of individuals served.

A single visit to a home is to be counted as one visit if service is rendered to only one individual, or as two or three visits if service is rendered to two or three individuals for whom separate entries are made on each individual's case record or special report.

Visits are to be classified by the service in relation to which they are given.

The nature of the nursing care given should determine the particular service and sub-classification in relation to which the visit is to be counted.

A visit to an infant carried only during the post-partum care of mother should be listed as a visit to New Born under heading of Maternity and New Born Service.

A visit to an infant as part of continuous health supervision, irrespective of care of mother should be listed under heading of Health Supervision Service.

Visits to contacts of communicable disease cases and to individuals suspected of having a communicable disease should be listed under the service for that disease.

For definitions of special classifications in relation to tuberculosis see definitions under section on Cases, page 589.

Visits to chronics, as recommended by the N.O.P.H.N. Service Evaluation Committee, should be limited to those cases specified as such by the insurance companies with which an agency has contracts, but for nursing practice in general the term chronic should be disregarded.

Morbidity Service is care of sick persons under or pending medical supervision.

Communicable refers to cases listed as such by local Boards of Health.

CONFERENCES AND CLINICS

Conferences and clinics are meetings arranged for at a definite time and place for examination or inspection and individual discussion of health problems or disease conditions.

Conferences may be either medical or nursing.

Clinics are always in charge of a physician.

Attendance at a conference or clinic is the number of individuals served and for whom entries are made on individual case records.

SCHOOL SERVICE

In a generalized nursing program, school work includes all activities in relation to school nursing which are carried on within the school building.

Where school work is a special service, it will include activities in relation to school nursing carried on outside of the school building as well.

Pupils excluded or readmitted as reported by nurse are those for which action is taken by the school principal on the recommendation of the school nurse.

Complete health inspection by nurse is one which covers such items as given on N.O.P.H.N. record form, School Health Record. (N.O.P.H.N. 63.)

EDUCATIONAL ACTIVITIES

Educational activities include meetings addressed or attended by staff for educational purposes, also preparation of educational exhibits, etc.

ORGANIZATION ACTIVITIES

Organization activities include meetings attended, individual conferences, and time spent in any other activities related to the development of the local work.

TIME DISTRIBUTON

Time studies should include time spent in the various staff activities, in travel, and in office. Time spent in office includes work on records, reports, and other office duties.

Whether or not daily reports of time distribution should be kept regularly or periodically depends on their value to the administration and organization of the agency.

CASES

Case in Morbidity Service is one in which care is given in relation to instances of different types of disease.

Case in Maternity Service is one in which care is given in relation to one pregnancy. An individual carried through more than one

* Definition as given in Appraisal Form, 1926, of American Public Health Association, 370 Seventh Avenue, New York City.

stage of maternity, such as ante-partum and post-partum, represents only one case.

Case in Health Supervision Service is one in which care is given within the age period used in the sub-classification of health supervision, an infant, preschool, school, and adult age group.

A count of cases is not necessarily a count of individuals. If a count of individuals is desired, it must be made separately from the count of cases.

New Case is:

For all services:
One coming under care for the first time in a current year.

For Maternity Service:
One which comes under care in current year in relation to a new pregnancy.

For Health Supervision:
One where the individual passes from age group to another age group.

For Morbidity Service:
One where an individual has been previously nursed in a current year and comes again under care with a different type of diagnosis.

Readmitted case is one which has been previously dismissed in the current year and comes again under care within the year, with the same pregnancy in Maternity Service, with the same diagnosis in Morbidity Service, and belonging to same age group in Health Supervision Service.

Terms relating to tuberculosis as defined by the National Tuberculosis Association:

Contact case is one in which the individual under care has at some time resided in close contact with an open case of tuberculosis.

Suspect case is one in which the individual under care presents suggestive symptoms or signs of tuberculosis either from his history or physical examination, including X-ray and tuberculin reactions, but for whom a positive diagnosis has not been made.

Post sanitarium case is one in which the individual under care has had at least three consecutive months' treatment in a sanitarium at any time.

AGE GROUP

Infant: under 1 year.

Preschool: 1 year of age and under 6, if not in school.

School: 6 years of age and under 14 and others in school.

Adult: all 14 years of age and over, if not in school.

INDIVIDUALS UNDER CARE IN A YEAR

Individuals under care in a year are the different individuals in the community who have received care through any service within the current year.

DAILY REPORTING

Items to be reported daily are not suggested in detail here as they are determined by the information which agencies wish to include in their monthly and yearly reports.

MONTHLY REPORTING

As information essential for annual reports can be most easily summarized month by month, a large number of details are reported monthly. It is not necessary to include all the items in the formal monthly administration reports.

Monthly summaries, depending on the nursing program of the agency, should include information on some or all of the following:

STAFF *

1. Number of nurses on duty during month: Total
   a. Supervisory
   b. Field
2. Number of staff days off duty: Total
   a. Vacation
   b. Sick leave
   c. Absent

FIELD SERVICE

A. Visits

1. Total number of visits for month
2. Classification by type of service

Suggestions for Particular Types of Agencies:

Agencies having principally a maternity morbidity service

A. Total number of visits:
   1. Visits for Maternity and New Born service: Total
      a. Ante-partum
      b. Delivery
      c. Post-partum
      d. New Born
   2. Visits for Morbidity service: Total
      a. Non-communicable
      b. Communicable
   3. Visits for Health Supervision service: Total
      If desired, may be classified by age group

Agencies having principally health supervision and communicable disease control service

A. Total number of visits:
   1. Visits for Maternity service: Total
      a. Pre-natal
      b. Post-natal

* Agencies having student nurses should keep a separate record of number of students on duty and of their work.

2. Visits for Health Supervision: Total
   a. Infant
   b. Pre-school
   c. School
   d. Adult
3. Visits for Communicable Disease Control: Total
   a. Tuberculosis: Total
      (1) To positive cases
      (2) To cases under observation
         (a) Contact
         (b) Suspect
         (c) Arrested
      If desired for total—
         Visits to post-sanitarium cases
   b. Other diseases: Total
      If desired, specify by type of disease.
      (1) To positive cases
      (2) To suspect cases

The preceding plans for headings assume that visits, In behalf of, Not found, Not home, and Not taken up, are included, under each type of service, with visits to homes when patient is seen. If it is desired to keep separate count of these visits the following additional headings may be used in the monthly reports of visits:

1. In behalf of: Total
2. Not home and not found: Total
3. Not taken up: Total

It is also suggested that in agencies having a health supervision and communicable disease control service a special count be kept of total visits in which demonstration nursing care is given.

Agencies charging for their services may wish to report on visits according to the pay status. It is suggested that this report be based on the financial statement of number of visits for which pay was received during the month, as:

1. Number of full pay visits
   a. Patient
   b. Contract
2. Number of part pay visits

B. Cases

1. Case load or case census by type of service
   Following information for each service
   a. Total cases under care during month
      (1) Under care at beginning of month
      (2) New during month
      (3) Readmitted
   b. Cases discharged during month
   c. Cases carried to next month
2. Analysis of cases
   It is recommended, because of the greater ease with which it may be done, that dismissed cases be analyzed monthly.

Analysis by type of service as follows:

1. *Maternity Service or Maternity and Newborn Service:* Total number of cases
   a. Reported by
      (1) Family
      (2) Physicians
      (3) Insurance agents
      (4) Nurse
      (5) Others
   b. Type of care given
      (1) Ante-partum and post-partum
      (2) Ante-partum only
      (3) Post-partum only
      (4) Newborn only
      If delivery service is provided, delivery data should be included with above headings.
   c. Condition on discharge
      (1) Mother
         (a) Discharged before delivery
         (b) Normal delivery and recovery
         (c) Complications requiring further care
         (d) Dead
            Specify cause
      (2) Infant
         (a) Normal
         (b) Condition requiring further care
         (c) Stillbirth
         (d) Dead under 1 month
            Specify cause
   d. Pay status
      (1) Pay: Total
         (a) Patient
         (b) Contract
      (2) Part pay: Total
         (a) Patient
         (b) Contract
      (3) Free
   e. Color *
   f. Nativity *
2. *Morbidity Service:* Total number of cases
   a. Reported by
      (See Maternity Service for subclassifications)
   b. Age group
      (1) Infant
      (2) Preschool
      (3) School
      (4) Adult
   c. Condition at discharge
      (1) Recovered
      (2) Improved
      (3) Unimproved
      (4) Dead
   d. Pay status
      (See Maternity Service for subclassifications)
   e. Sex *
   f. Color *

* See page 591.

g. Nativity *
h. Diagnosis
(1) Acute communicable disease
(If desired specify diseases)
(2) Respiratory diseases (exclusive of tuberculosis)
(3) Tuberculosis, all forms
(4) Heart
(5) Cancer
(6) Nephritis
(7) Diabetes
(8) Diarrhea and enteritis
(9) Accidents
(10) Other
(If desired specify)

It is suggested that agencies having a large volume of service and desiring a detailed analysis by diagnosis classify each of these diagnoses by such of above headings as they wish, and in addition give number of visits made.

3. *Health Supervision:* Total number of cases
a. Age group
For sub-classification see 2. Morbidity Service, b. Age group
b. Color *

MEDICAL OR NURSING CONFERENCES AND CLINICS

Following information for each type of conference and of clinic.

1. Number of sessions held
2. Visits
a. Total
(1) Old
(2) New
3. Cases registered
a. Total cases under care during month
(1) Under care at beginning of month
(2) New during month
(3) Readmitted
b. Cases discharged during month
c. Cases carried to next month
4. Patients examined by physician
a. Total
(1) First examination
(2) Re-examinations
5. Patients referred for nursing follow-up because of abnormal conditions or defects.
a. Total referred:
Number for
**(1) Teeth
(2) Vision
(3) Hearing
(4) Nose or throat
(5) Heart
(6) Lungs
(7) Skin
(8) Orthopedic
6. Defects found
a. Total found:
(See list under 5)
7. Corrections made
a. Total made:
(See list under 5)

OTHER ACTIVITIES

A. Classes or clubs
1. Type
a. Number held
b. Attendance
B. Meetings in community
1. Meetings addressed
a. Number
b. Subject
c. Approximate number reached
2. Number of meetings attended
3. Number of staff meetings
4. Number and type of other meetings

SCHOOL SERVICE

A. Activities in school
1. Number of schools visited
2. Number of classrooms visited for group inspection
3. Number of pupils referred by teacher for individual inspection: Total
a. Number excluded
b. Number readmitted
c. Other
4. Number of cultures, etc., sent to laboratory: Total
Specify type
5. Number of completed immunizations, nurse assisting: Total
Specify type
6. Number of health examinations by physician, nurse assisting: Total
a. Number with parents present
7. Number of nurse's inspections for physical defects: Total
a. Complete inspections
b. Special inspections: Total
(1) Vision
(2) Hearing
(3) Dental
(4) Other
8. Number of pupils referred for nursing follow-up because of abnormal conditions or defects:
(See details as given under Medical or Nursing Conferences and Clinics: 5-a.)
9. Number of consultations with teachers
10. Number of consultations with parents in school: Total
a. Individual
b. Group
11. Number of classes taught
By type and attendance

* The advisability of reporting on these items should be determined by the fact that the information is needed for special studies or that any of these facts present an organization problem in the community.

** List as given on Appraisal Form, 1926, of American Public Health Association, 370 Seventh Avenue, New York City.

12. Number of building inspections
    a. Number referred for attention
       Specify reasons

If the school service is being done as a specialized service, the following report should be made, otherwise these items should be combined with similar items under the general report.

B. Activities outside of school
   1. Number of field visits for school children: Total
      a. Health supervision
      b. Communicable disease control
      c. In behalf of
      d. Not found and not home
         (*c* and *d* may be combined with *a* and *b*)
   2. Number of group meetings with parents
      a. Attendance
   3. Other activities

TIME DISTRIBUTION

A. Total time on duty
   1. Time spent in staff activities
      a. Field visits
      b. Conferences and clinics
      c. Educational activities
      d. Organization activities
      e. School service.
      f. Other activities
   2. Time spent in office
   3. Time spent in travel

YEARLY REPORTING

The yearly report is based on the details which have been reported currently. In addition to these details which have been reported monthly, the yearly report may include certain special counts as of individuals Under Care During Year or of corrections made in connection with Conferences and Clinics and with the School Service.

The report on individuals under care should include:

1. Total individuals
2. Age group of individuals

Following are suggestions for making certain yearly counts:

CASES IN FIELD SERVICE

A. Case load or case census
   The total for each service will be:
   1. Number of cases carried from previous year to beginning of current year.
   2. Sum of new cases admitted each month.

The total for all services will be the total of the case load or case census of each service.

B. Analysis of cases
   Agencies carrying a large number of health supervision cases, tuberculosis cases or other cases of long duration and which are still under care at end of current year, should analyze these cases on the same basis as the monthly analysis of dismissed cases.
   This information is to be added to the totals of the monthly analysis of dismissed cases to give a true picture of the type of all cases carried in a year.

CASES REGISTERED IN CONFERENCES AND CLINICS

The total registration for each conference or clinic will be:

1. Number of cases carried from previous year to beginning of current year.
2. Sum of new cases registered each month.

INDIVIDUALS UNDER CARE DURING YEAR

This count can not be made directly from the case records. It may be made from:

1. Family folders, if a separate file is kept for families under care in the current year.
2. Index card file, if these cards are filed in two files, which are
   a. Current year file
      In this will be filed cards of all individuals coming under care in a year. This file at the end of the year will give a count of individuals to whom the agency has given care.
   b. Permanent file
      In this will be filed the cards of individuals who have ever at any time been under the care of the agency. When an individual comes under care for the first time in the current year, his index card is taken from this file and put in that of the current year.
3. Special cards prepared for statistical studies.

PAY STATUS OF VISITS

A report for a year may be made on visits by agencies, charging for their service.

1. Number of full pay visits
   a. Patient
   b. Contract
2. Number of part pay visits
3. Number of free visits

On the basis of a year the number of free visits will be the total number of visits for the year, minus the sum of the the number of full pay and part pay visits.

The Rugles Baby—In Three Chapters

This story comes to us from the Visiting Nurse Association of St. Louis, Missouri.

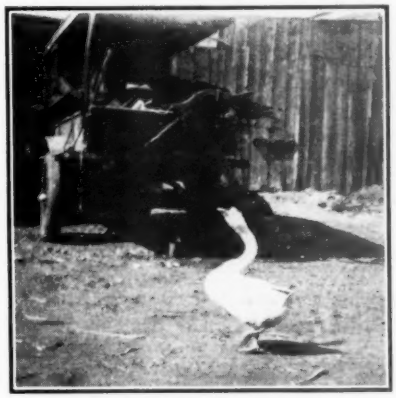
CHAPTER ONE

PASSING through a dirty back yard, strewn with rubbish, tin cans, ashes and pieces of kindling, we approached the Rugles home. Barring the doorway was the largest gander I have ever seen—a grimy, feathered bird who had not the slightest inclination to budge from his place in the sun to permit us to pass into the house. By the time we had stumbled over a few of the old bottles and cans, and had actually encountered and remonstrated with the goose, my opinion of the standards of the family we were about to visit was already formed, and I was prepared for shiftlessness and dirt. How little I knew the true situation!

One of our nurses had been visiting the home for some four days to give care to Mrs. Rugles and a newborn babe. This little girl was prematurely as well as unfortunately born, weighing only a fraction over three pounds. The mother was doing well and the baby thrived fairly well for the first two days, but on the third the nurse noticed symptoms that seemed none too good. The temperature was subnormal and her respirations were somewhat shallow. Mrs. Rugles observed that the baby slept continually, not even waking when she tried to nurse it. The doctor had already assured us that everything was being done that was possible for the infant, and that it would probably not live.

On learning that this seemed such an accepted fact, we decided that we should like the baby to have a further chance. Thus the reason for my visit to the home with the nurse who was giving care. After Mrs. Rugles had observed that I wore the same uniform as her nurse, and was thoroughly convinced that I was the same kind of a nurse, she lost her shyness and talked of herself and her troubles—and troubles she had in heaps.

At the time of the tornado last fall her home and all the furnishings were destroyed while she and her family



Goosey, Goosey, Gander

were standing in an outer hallway, the only part of the house unharmed. Two days later her father, who had been badly hurt in the storm, died in a hospital. Three months later, and about two months before this premature baby was born, her husband "had to go away"; in other words, he was sent to the penitentiary for three years, and left her with two young children, one seven and one six, to care for, with this other baby on the way. Since the enforced absence of Mr. Rugles, one of the relief agencies had been giving the family $5.00 a week with which to buy food. Her husband's brother, who appeared to be the plutocrat of the family, lived upstairs in this ramshackle house and furnished the rent and the coal for the Rugles family.

CHAPTER TWO

The next chapter in the series of misfortunes was that Mrs. Rugles slipped and fell from the back porch and the baby was born four weeks too soon, and it just did not look as if the little mite—already named Mary—

could live. The rooms were furnished scantily, although there was a fairly good heating stove in the bed room, and a clothes basket had been borrowed from a neighbor with enough hot water bottles to keep tiny Mary comfortable and warm throughout the day. But stoves do have to be replenished during the night and hot water bottles have to be refilled too to keep them from becoming ice bags; and although kind neighbors tend the fire and heat the water during the day, one finds that the night is long and dreadfully full of fears.

We found our mother very worried and harassed this morning, for Mary was decidedly weaker. Her respirations were so shallow that they could barely be felt by placing a finger on her chest. She did not rouse at all when the nurse gave her a partial warm-oil bath and her condition seemed critical indeed. Something must be done and soon. Mrs. Rugles fully realized the situation, and could not help explaining how helpless she would be if the baby died at night or at any other time when she was alone.

We mentioned the premature room at Children's Hospital and she clutched at the possibility of placing the baby there. She was certain her doctor would not mind if Mary was sent there—only there was the old question of expense. We assured her that if the doctor would give his consent perhaps the baby could be taken to the hospital that afternoon, and with no financial obligation to cause her additional worry. By a pre-arranged plan, one of the nurses was to make a trip that afternoon to a near-by clinic to take an old lady who was too weak to travel on the street car. This was a solution for getting the baby to the hospital if other obstacles could be overcome.

The physician seemed to be a busy man that day and we were unable to locate him. We went on to the clinic with the other patient and while there we consulted the pediatric social worker and were assured of a free bed in Children's Hospital in case the doctor's permission was granted. Finally the doctor was reached and informed of the baby's condition. With much tact and diplomacy, and not a little temerity we suggested hospitalization and ventured that we might arrange through the social service department to secure a free bed in Children's Hospital. He was eager for us to go ahead with this plan, so there was another obstacle overcome. All that was left to do was to go after the baby and get it to the hospital. How we hoped that it would still be alive!

CHAPTER THREE

On the second approach to the house we did not notice the cans or the rubbish or even the big goose in the doorway, we were so eager to get there. Mrs. Rugles wept when she saw us, for she had given up hope of getting anything done for Mary that day and the baby's condition had not improved. She actually looked happy when she saw the tiny bundle being carried away in the arms of the nurse whom she trusted! The ride to the hospital was unforgettable. We were in such a hurry, yet it was necessary to drive very slowly so as not to shake up this little mite too much. The seemingly never-ending distance was finally covered, and somewhat in a daze we watched two doctors and a nurse take the baby in charge, saw the tiny bed prepared and watched oxygen administered, for by this time the baby was scarcely breathing. While we still watched, Mary opened her eyes, and seemed much brighter and so we left her, after taking instructions for the mother concerning the pumping of her breasts and getting the breast milk to the hospital each day.

With much eagerness we called the doctor at the hospital the next morning and found that Mary was actually taking a feeding out of a regular sized bottle and nipple and was showing marked signs of improvement.

The Public Health Nurse and Home Safety

By Rosebelle Jacobus
Director, Worcester Society for District Nursing, Worcester, Mass.

Editorial Comment: There is not a day in which the public health nurse does not see carelessness, thoughtlessness and recklessness on the part of people in general. Much of it she cannot remedy because her suggestions would not be graciously received, nor can she spare the time from her appointed task. An opportunity, however, which is both her duty and her privilege, is to advise her patients and her patients' families against the daily risks which they heedlessly—sometimes ignorantly—run in their own homes. The National Safety Council is eager to supply public health nurses with information and facts as to home accidents and their prevention.*

The tragic word pictures of the results of home accidents sent us by Miss Jacobus may serve to awaken a keener sense of responsibility toward the safety of those for whom we care. A few references are given relating to the daily commonplace hazards we all meet, not to make us timorous, but that the great adventure of life may not be unduly shortened.

"MOTHER, may I put on my brand new dress and go down and sit on the door step?" asked seven year old Janie. "Yes, dear," said the mother, "but do not go out of the yard and try not to get dirty." . . . "Nurse," said the mother next day, "Mary did just what I told her to do. She was sitting on the door step holding her doll. You know we are very near the street. Two men came along, talking, and one just flipped his cigarette away without looking. It came over the fence right into Janie's lap and in a second she was on fire. Of course she ran and screamed and that made the blaze worse. When I reached her it was too late, she died an hour later. . . . No, we don't know the man who threw the cigarette, he never even turned to see what the screaming was about. Just a careless, thoughtless act, but I have no daughter."

There are not many of us who realize or perhaps care to realize the results of our careless acts, but all public health nurses and social service workers see again and again results which make the heart ache and create a righteous anger.

There is Johnny, an only son, who has been in the hospital for three months, with an extension from his hip down and a six pound weight on the end of it, all because his sister dropped a marble on the floor and did not pick it up. Johnny is losing his schooling, his family has been caused unnecessary anxiety, and has had to go into debt to pay his hospital expenses.

In another family the mother has been in bed for the past six months because a banana skin was thrown on the sidewalk by someone too careless to drop it into a trash can.

Recent items from newspapers speak urgently to social workers into whose lives the opportunity to say a word of warning comes daily:

Four boys were drowned when a home-made raft tipped over in two feet of water. The boys could not swim, but because the water was only two feet deep the parents had not thought to warn their boys to keep away.**

The doctor gave mother two bottles of pills for headache. Mother coming home in a hurry laid them on the kitchen table. Leon, aged four, and Jenny, aged three, found them. Suddenly mother heard Leon say, "That's good candy, isn't it?" Knowing that there was no candy in the house the mother ran into the room where the children were and found that they had eaten the contents of the bottles. Both children were rushed to the hospital in critical condition.

A child finds matches on the table and sets fire to a curtain. Sixteen children were injured in the rush to get out of the house.

In trying to start a fire in the kitchen stove with kerosene a mother was badly burned, and a child in outing flannel night-

* See The Public Health Nurse, November, 1927, p. 558.
** See Life Saving Courses, American Red Cross.

gown burned about her legs and body. Another child in this family was badly burned a year ago from playing around a bonfire.

The increased use of gas and electrical household appliances, even in the poorer homes, has made living more hazardous, especially for those who cannot read directions in English. The National Safety Council publishes a leaflet on "Safe Use of Gas in the Home" with particular emphasis on the danger from imperfect tubing and leakages. The following true experience illustrates a frequent hazard, too little thought of.

The nurse stopped in the middle of the block. She had been over the same ground in the morning. She remembered some advice she had given to the tenant on the second floor. Now she stood and sniffed and sniffed, every window closed but behind those windows? She flew to the second floor, opened the door and stepped back. Illuminating gas poured out. She ran out to the piazza and called a man in the street. Covering their faces they went through the rooms and opened the windows. The father and mother were sitting in a heap at the dining room table, the meal half eaten before them. The five year old on the floor and in his hand the end of the tubing from the gas stove. The baby in the cradle asleep with the covers over her head. The ambulance came with a doctor and pulmotor and after much strenuous work the family, except the father, were on the road to recovery.

"Oh, Nurse," said the mother, "and only this morning you told me what would happen if I let Johnny play around the gas stove. I told him not to touch it, but I forgot to watch him."

In spite of the vigilance of insurance companies, public utilities and other agencies, hundreds of accidents occur every year from broken insulation of electrical equipment or overheating A few simple rules issued by the National Safety Council should be borne in mind:

Frequent inspections for weakness, wear or breakage should be made.

Wiring for stairs should provide switches at both top and bottom.

Fixtures should be out of reach of one standing in a bath tub or where the other hand might be touching a stove or other metal object liable to be grounded.

Especial care should be taken to assure perfect insulation in cords, drops, extensions and switches either in regular circuits or connecting irons, stoves, washing machines toys or other mechanical home equipment.

Discontinue the use of any fixture where broken insulation is discovered or where the slightest shock is felt, until it is repaired.

Never leave electric irons, curlers, grills or other electrical devices generating heat while turned on or where there is danger of fire from overheating.

Some cleaning fluids, gasoline, kerosene and the pyroxylin plastic compounds, such as celluloid, pyralin, fiberloid and the like are all dangerous near flame or heat. All containers should be kept outside the house, and the fluids poured only in the daytime. Especial warning is issued in the use of eyeshades, which may be ignited by heat and have frequently caused partial or total blindness.

A course of study in Home Accident Prevention—six lessons—is an effort on the part of the National Safety Council to supply and offer for distribution a series of outline studies in home hazards that will form a guide to individuals and organizations desiring to assist in meeting this problem. As a study course for women's clubs these safety lessons are both valuable and popular.*

* National Safety Council, 1 Park Avenue, New York City.

The meetings of the National Safety Council, held in New York October 1–5, provided much of interest to public health nurses. A report of the meetings with plans for coöperation of public health nursing services in safety measures will be published in the December number.

Under the American Red Cross

MARY SEWALL GARDNER, R.N.

DURING the past summer the *Red Cross Courier* brought out a series of articles on the Red Cross Public Health Nursing Service. These articles have recently been collected and published in pamphlet form under the title "What the Future Holds for Public Health Nursing under the American Red Cross."

This pamphlet should have more than passing interest, not only because it is written more or less as an *apologia pro vita sua* of one of the most important nursing services of our country, but also because in it Miss Fox raises searching questions regarding a number of the as yet unsolved problems of public health nursing. Intended primarily for Red Cross consumption, it should not be limited in its distribution to the Red Cross alone. Miss Fox is one of the clearest thinkers the American public health field has produced, and it is well worth our while to consider carefully what she has to say on a subject on which she has become a leading authority.

For those to whom the Red Cross Public Health Nursing Service is unfamiliar, a word as to its history may be pertinent. Started as a rural nursing service in 1912, it had attained an inconspicuous but assured place for itself and its hundred odd nurses, when the War shook to the foundations all public health nursing. It was owing in no small part to the existence of this service, backed as it was by the National Organization for Public Health Nursing, that the work of the public health nurse, thus protected under the powerful wing of the Red Cross, was enabled to weather the storm, and emerge from the War stronger, instead of weaker for the experience. The years 1919, 1920 and 1921 were perhaps as great a strain on Red Cross leadership as the War years themselves, for during that period came that great boom in public health nursing which so taxed the wisdom of everyone concerned. Hundreds of chapters with money in hand sought to establish nursing services over night. Many of them were ready to build carefully for a future of stability and strength, but many more were without any realization of the sustained effort required for the task.

During these critical years of unexampled expansion three points of view were held regarding the question of Red Cross responsibility in the public health nursing field.

One large group, accustomed by the War to Red Cross leadership, and liking the idea of a centralized body, seeing too the helplessness of the average rural community, were all for the fullest possible assumption of responsibility by the Red Cross. When assured that local initiative and the financial responsibility of the community would be strengthened, they were wholly satisfied that in no hands could public health nursing standards be so safely trusted.

A second group felt quite differently. They deplored the unnatural centralization of effort in every field, made necessary by the War, and felt that no matter at what cost, the country should as quickly as possible decentralize everything and return to a post-war basis of complete local initiative.

Between these two groups was a third, which felt that there was a temporary, though not a permanent need for Red Cross support, and that though this should be enlisted in fullest strength for a few years, every effort should at the same time be made for withdrawal at the earliest possible moment.

What has the history of the ten years since the signing of the Armistice taught us in regard to these three points of view? The mere grinding of the mills of cause and effect has taken care of some of the problems. Where

sufficient local initiative has been lacking to vitalize the work, it has died a natural death despite national interest and regret. The mortality among hastily formed and poorly organized services has indeed been great, but this mortality is decreasing and a turn of the road seems to have been reached. As late as 1926, 72 services were dropped or turned over during the year. In 1927 but six were so disposed of, and this small loss was offset by the addition of 68 new and 40 reopened services. It would therefore look as if Red Cross responsibility were destined to continue and to increase in the coming decade. This is Miss Fox's opinion, and in her pamphlet she gives her reasons for believing that this should be so.

Certainly we cannot remain indifferent to the fact that fifteen hundred or more counties are without a nursing service, and that upwards of fifty million people in our country are being served by but two thousand nurses more or less, and we must welcome any efforts, by whomsoever made, to solve the problem of a better provision for so large a number of our fellow countrymen.

FOUR OUTSTANDING NEEDS

A reading of the pamphlet would seem to show four outstanding needs in rural and small town America, which can be better met with the aid of the Red Cross than in any other way.

First. A number of counties have already under Red Cross leadership developed one and two nurse services, wholly inadequate it is true for the need, but a beginning. To discover a way to carry these beginnings into something more nearly adequate requires the consideration of a body accustomed to such study and analysis, and possessing also data for comparison. The counties are hardly in a position to work this out for themselves.

Second. Most of the more rural counties are without bedside nursing for the sick, or nursing care for maternity cases. Are we going to sit down under such a situation and say "It cannot be provided"? Do we not need the continued effort of the Red Cross to find a way to meet these needs?

Third. Where a twelve-months-a-year service is impossible, the Red Cross has devised a plan which provides itinerant nurses who go from county to county, giving a three months' service to each every year. Such an arrangement can be possible only under a centralized body able to adjust the practical details of the service, and to guarantee the all the year round salary of an unusually qualified nurse. Fifty-six such itinerant services are now functioning with a probability of a steady increase each year.

Fourth. Many believe that the only way to provide universal countrywide public health nursing is through the assumption of responsibility by public bodies, state, county or local, such a responsibility as has already been assumed for universal countrywide education. Easily said, but we have learned that public bodies in many localities are not yet ready for such a responsibility. Either they do not want it, or will assume it without sufficient knowledge or understanding of the work to assure safety of standards or continuance of effort. The Red Cross has already done much to work out constructive relationships between voluntary agencies and health officials in both counties and small towns, relationships which will assure to the nursing service the advantages to be derived from both; and at the same time afford protection from undue political interference. Again, we must say that a strong centralized body like the Red Cross, unaffected by the breezes of local conditions and politics, is needed to help effect this combination of effort.

A good piece of work has been done. Even those who most feared the dangers of a centralized responsibility must admit that the Red Cross has been successful beyond expectation in fostering local initiative, and in making desirable tie-ups with official bodies. Without its timely aid our rural communities would have been the

poorer. We are prepared to move more slowly now than in those hectic years of speeding-up that immediately followed the War. A "vanishing program" meant at that time a program that would vanish in the twinkling of an eye. Miss Fox but proves in her little pamphlet what most of us have learned in our own work, that ten years is a very short time in which to plow and sow, and that few harvests in the public health field come to fruition in that length of time. In acknowledging the failure of a demonstration plan for so large an undertaking, and in substituting for it a long time program of continued work, the Red Cross is acting on an experience common to most health workers.

The Red Cross should have the support and sympathy of all public health nurses as it enters the second decade of post-war work in that great field of need, rural and small town America.

THE WINTER HARVEST

"In the Winter, pleurisies, inflammation of the lung, lethargies, rheums in the head, hoarseness, coughs."—Hippocrates, B.C. 400.

·THE·MORNING·BLOW·

From *Maternity and Child Welfare*

MY NOSE

It doesn't breathe;
It doesn't smell;
It doesn't feel
So very well.
I am discouraged
With my nose:
The only thing it
Does is blows.

—Dorothy Aldis

From a perhaps more serious point of view Dr. John J. Abel said recently, in announcing a gift to Johns Hopkins University for a study of the cause of colds:

Colds are of importance, not only because of their extremely common occurrence and the great aggregate of minor sickness which they cause directly, but also because of the relation which they may bear to pneumonia—a relation which requires much more extensive investigation. There is also the question of the relation which exists between common colds, ordinary "grip" and epidemic influenza. Clinically the cases overlap, so that there is no clear distinction between a severe cold and a case of grippe, or between grippe, as seen perennially, and the influenza which occurs in epidemics. There is also need for more study of the bacteriology of these diseases, for while it is believed that they are infectious, bacteriologists have not yet succeeded in identifying with certainty the particular bacteria or viruses which may be responsible.

The New York Commission on Ventilation, studying especially the one room, county ungraded schools, have come to the conclusion that country children suffer more from colds and coughs than city children. The absenteeism rate due to colds, sore throat and coughs was about twice as high in the rural districts. The prevalence of colds was in inverse relationship to the atmospheric temperature. When the thermometer was lowest colds were most prevalent. During cold weather, snow and rain were more important factors than the cold itself in causing colds. As to methods of heating, investigators gave the old fashioned stove the premium.

WHAT IS THE INTERNATIONAL COUNCIL OF NURSES?

Compiled from notes furnished by Miss L. L. Dock, for many years secretary of the Council, by Miss Christiane Reimann, and Miss Nina Gage.

What is the International Council of Nurses? When, where and how did it come into being?

At the World's Fair in Chicago, in 1893, a Section on "The Hospital Care of the Sick; Training of Nurses; Dispensary Work and First Aid to the Injured" of the International Congress of Charities, Correction and Philanthropy, held meetings. With it met—for the first time in history—as a subsection, an international gathering of nurses, with Isabel Hampton as chairman.

Ethel Gordon Fenwick, Founder of the Council

Mrs. Bedford Fenwick, as delegate from the Royal British Nurses' Association, attended this meeting. At the same time an inconspicuous gathering of the then very youthful International Council of Women, with Mrs. May Wright Sewall of Indianapolis as chairman, was holding meetings. Mrs. Fenwick was attracted to the meeting by the word "International"—which even in the last century had some reputation! At the close of the meeting Mrs. Fenwick was commissioned to urge in Great Britain the formation of a National Council of Women. This was later organized and became part of the International Council of Women.

When the International Council of Women (by that time a far more important body) held its Quinquennial Meeting in London in 1899, a group of British nurses, stimulated by Mrs. Fenwick and other leaders, asked for room on the program for a nursnig subsection. Following the meeting of this subsection, it was proposed at the Matron's Council then holding its annual meeting in London—at which a number of foreign nurses representing ten nations, among them Miss L. L. Dock and several other American nurses, were present—that "steps be taken to organize an International Council of Nurses."

The resolution was unanimously adopted. The constitution was adopted in July, 1900 (amended in 1909), with the following preamble:

> We, nurses of all nations, sincerely believing that the best good of our profession will be advanced by greater unity of thought, sympathy, and purpose, do hereby band ourselves into a confederation of workers to further the efficient care of the sick and to secure the honor and the interests of the nursing profession.

The constitution gives six countries represented among the foundation members. The first President of the Council was Ethel Gordon Fenwick.

It is a point of interest that Mrs. May Wright Sewall was present at the meeting at which this resolution was proposed.

For some years the International Council of Nurses was affiliated with the International Council of Women, which desired to include in its membership as many representative bodies as possible. Later it was decided to embark on an independent existence.

Public health nursing came into early notice at all these meetings. At the nursing subsection at the World's Fair in Chicago in 1893, Florence Nightingale contributed a paper on "Sick Nursing and Health Nursing," with health messages as modern as if written to-day. A number of papers on

District Nursing in England and America were also given, with Amy Hughes and Mrs. Dacre Craven representing the English work.

At the London Congress in 1909, public health work was embodied in an attack on prostitution, preceded by articles in the papers published in the interest of English nurses. An original investigation was made by Miss Burr, a nurse, and presented at this Congress. For that time a bold procedure indeed! In the Cologne meeting in 1912 the German nurses attacked "over-work and over-strain."

The Chicago meeting (even though held before the actual formation of the Council) has been called the First International Council of Nurses, the London meeting of 1899 (the date of the foundation of the Council) the second. Later international congresses have been held as follows:

1901—Buffalo
1904—Berlin
1907—Paris
1909—London
1912—Cologne
1922—Copenhagen } Business meetings
1923—Copenhagen } only
1925—Helsingfors
1927—Geneva (Interim conference)

International meetings were planned to be held in San Francisco in 1915 and in Atlanta in 1920. On account of the war few foreign nurses were able to attend, and nothing was done beyond the planned conventions of the American national nursing organizations.

Up to the meeting in Helsingfors in 1925 the work of the International Council of Nurses was mainly done through its congresses. The Helsingfors meeting—the first since 1912—at which 33 countries were represented, inspired important changes and developments. International Headquarters was established in Geneva, with Miss Christiane Reimann as Secretary. A quarterly magazine, *The I.C.N.*, was instituted, the first number appearing in January, 1926. Standing committees on public health, nursing education, private duty and mental hygiene were appointed. Nineteen countries, through their National Association of Nurses, are now affiliated with the Council.

Voting Body. Members — The Nurses' Associations of the affiliated countries. Each affiliating association sends to the quadrennial congresses four delegates, elected or appointed, as each affiliating association decides it prefers. These comprise the *Grand Council.*

Board of Directors. In addition, to carry on the work of the Council between congresses (which is the only time the Grand Council convenes) five officers are elected at the congress for the ensuing four year term:

President
First Vice-President
Second Vice-President
Secretary
Treasurer
National representatives (who are the presidents of the affiliating nursing associations)

Dues. Paid by each association at five cents United States currency for each member as of January 1st. For example:

70,000 members of American Nurses' Association—$3,500 gold
10,000 members of British Nurses' Association—$500 gold—£100
1,200 members of Nurses' Association of China—$60 gold

Nurses planning to attend the Congress are requested to send their applications for accommodation to the Committee on Arrangements, Royal Victoria Hospital, Montreal.

Rooms have been secured in hotels, convents and boarding houses at rates varying from $1.00 to $5.00 per day. The rates in large hotels are:

Single room	$3.00–$4.00
" " with bath	$5.00–$7.00
Double room	$5.00–$7.00
" " with bath	$8.00–$10.00
Large room, 3 persons	$7.50–$10.00
" " 4 persons	$8.00–$12.00

On arrival in Montreal, visitors who have not already received room assignment are requested to report to Headquarters—The Montreal High School, University Street.

The preliminary program of the Montreal Congress will appear in December.

Educational Measures for Metropolitan Life Insurance Nurses *

Discussion by Alice Ahern, Assistant Superintendent of Nursing, representing Mrs. Helen LaMalle, Superintendent of Nursing, Metropolitan Life Insurance Company.

THE policy adopted by the Metropolitan at the time its nursing service was organized in 1909 was a broad one. It was not the desire of the company in any way to duplicate the efforts of nursing organizations by establishing an independent service for a restricted group of policyholders but rather to affiliate with the existing health agencies. This affiliation also increased the organization's financial support to a marked degree as visits extended to policyholders are paid for by the Metropolitan. At the end of the year 1909 affiliation had been arranged with 13 organizations, in 1910 the number reached 94, and today affiliation with 953 organizations has been effected.

Establishing Independent Nurses

With the rapid demand for, and the growth of the Metropolitan nursing service, as there were many towns that had no nursing organizations, it was necessary to organize a staff of independent nurses in these communities. As a result of this, the Metropolitan has today a staff of 592 independent nurses and its program of staff education is now well developed.

Institutes

Institutes, held twice a year in each territory, are a valuable part of the Metropolitan program of staff education. Each Institute is conducted by the supervisor of the territory in which it is held. At the Institutes lengthy discussions on various topics are not the rule. An effort is made to present practical demonstrations as well as instructions according to the following program:

Purpose of the institute.
How to plan a day and the approach in the home.
Demonstration of prenatal care.
Demonstrations of postnatal care and care of baby—use of trays.
Reading and its value as applied to a nurse's work.
The value of bedside care—the visiting nurse as a teacher.
Records and their value.
Comparative territory study of nursing service.
Round table discussion of local problems.

Nursing representatives from various public health organizations are invited to speak at the Institutes. Prior to the Institute, the nurses who are to attend are asked to submit their problems and questions to the Home Office or Head Office, these to be discussed as a part of the program.

Correspondence Course

The correspondence course was a result of an experiment tried in 1924 when a trial three day Institute was held in a city in the Middle West States. This was not only the beginning of the institutes now held regularly but it indicated to those in charge the necessity for a definite plan of educational work and as a result a correspondence course was started in March, 1925. This correspondence course was in no way to take the place of a public health course. It was intended to bring practical help to the nurses on their district problems, and to stimulate them to take public health courses. The correspondence course is compulsory and the results have been satisfactory. It is interesting to note that partly as a result of the cor-

* Given at N.O.P.H.N. Meeting on "Staff Education and Community Service," Biennial Convention, Louisville, Ky., June, 1928.

respondence course and the institutes to date 58 Metropolitan nurses in the United States and 16 in Canada have completed public health courses.

Coöperation with the University of Montreal

A School of Public Health Nursing has been organized at the University of Montreal for French speaking nurses. This school was opened in September, 1925, and is jointly subsidized by the Montreal University, the Provincial and local Health Departments, the Anti-Tuberculosis and General Welfare League and the Metropolitan Life Insurance Company. Nine students graduated the first year, eleven enrolled in September, 1926, when the school began its second year and eleven more in September, 1927.

Realizing the financial difficulties that many nurses encounter when taking a public health course, the Metropolitan assists the nurses financially in proportion to the length of the course taken. In addition special scholarships have been given to 25 nurses in the United States and to 16 in Canada. Thirty-five nurses have taken public health courses on their own account.

Practice Centers

Practice centers are also part of the Metropolitan educational program. As an experiment a practice center was established in Jersey City, N. J., three years ago to which newly appointed nurses in the Middle Atlantic States were sent for six weeks' experience and introduction to the district work. The following program has been perfected for the training of these new nurses:

> District observation under supervision including records; staff conferences; visits for observation of community resources sufficient to give an intelligent understanding of their use.

The training proved so successful that the Metropolitan has since organized and developed similar practice centers in New Orleans, Louisiana, Atlanta, Georgia, and in Montreal, Canada. The establishing of practice centers presents three very definite and practical opportunities:

Giving practical instruction under supervision.

Standardization of methods when the nurses are introduced to the district.

Giving the nurses a wider realization of their opportunities and responsibilities as health workers.

Floating Library

Last, but not least, on the program of our staff education is the floating library. The staff nurses are circularized from time to time with material such as abstracts from medical magazines and articles giving the latest information on scientific subjects. The library acts as a stimulus to the nurses and helps them with questions they would like to discuss at institutes. It awakens them to the needs of their communities and their own needs, broadening their minds and prompting them to do more reading and studying.

Annual Meeting of the American Public Health Association

THE Fifty-seventh Annual Meeting of the American Public Health Association, and the Fifth Annual Meeting of the American Child Health Association opened on the evening of October 15th in Chicago, with addresses by the president of the former, Dr. Herman N. Bundesen, and by the vice-president of the latter, Dr. Livingston Farrand. Dr. Bundesen pled for accuracy, simplicity and brevity in the publicity for which public health workers are responsible, for a wider use of publicity media, and an earnest personal effort to practice what we preach. Dr. Farrand conveyed greetings from the president of his association, and urged a more careful consideration and study of the relations between the officially constituted health authorities and the voluntary agencies.

Other joint general sessions in which the American Social Hygiene Association and the Women's Foundation for Health shared, were concerned with the achievements and needs of social hygiene, international health, the cancer problem, the economics of medical care, value of positive health and public health education. We hope to publish some of the papers from these joint meetings at a later date.

The large group of public health nurses found the papers and reports on maternal and infant mortality studies particularly thought-provoking. The United States has now, according to the last government report, become the most unsafe country in the world in which a mother may bear a child. Chile has bettered its record and stepped ahead of us in its maternal mortality situation. Arresting figures were presented from the Children's Bureau, from the New Jersey State Department of Health and from the Division of Research of the American Child Health Association. A variety of causes for our high death rate was cited, among them:

Inadequate theoretical training in obstetrics for medical students

Too limited practice fields

Midwife deliveries

Puerperal septicemia

Accidents of pregnancy (still on the increase)

Lack of prenatal care

Failure to apply the methods of community organization already tested and known to be effective

Lack of hospitalization for the middle class mother

Lack of adequate up to date provision for maternity care in many general hospitals

Examples were given of successful programs, among them the rural demonstration in Tioga County, N. Y., initiated by the Maternity Center Association and now taken over as a generalized service by the county. (See THE PUBLIC HEALTH NURSE for December, 1927.)

The section meetings on publicity were very popular. Dr. C.-E. A. Winslow was particularly happy in his summary of the criteria of good health education publicity. It must be true, important, comprehensive, acceptable and useful.

As always the opportunity for joint discussion between health officers and public health nurses was appreciated, and utilized. The sense of sharing in large community interests, and of helping others in the solution of problems by telling of actual experiences made the sessions helpful to large and small health departments alike. Meetings went off with a snap and promptness which was a five days wonder to everyone, and a boon to those who wished to slip from one section to another or to hold conferences after meetings. There could not have been a better planned schedule. Practically all meetings were held in the Stevens Hotel, which offered unusually ample, even palatial accommodations.

Nor was the lighter entertainment

of visitors neglected. Thoughtfully planned trips to all the public health centers, bus rides and excursions tempted one from the business of the day. The nurses enjoyed an informal and altogether delightful banquet at the Nurses' Club at which Professor Happy interpreted the program of the meetings as he understood them, in his humorous inimitable way. A grand banquet for all the visitors was held in the Grand Ball Room of the Stevens on Thursday evening.

Throughout the meetings there was an informality, a leisureliness due to the strict observance of a time schedule by those presenting papers and an encouraging sense of sound progressive accomplishment which to this member at least were unique, and greatly to be desired at all conventions.

DOROTHY DEMING

REGIONAL CONFERENCE ON SOCIAL HYGIENE

The Annual Regional Conference of the American Social Hygiene Association held at Louisville, Kentucky, October 11–13, had a registered attendance of 250, representing 16 states and 21 cities. The meeting was a real inspiration and stimulation to those present. Space will not permit a complete discussion of the meeting but certain papers especially pertinent to the work of the nurse may be mentioned. Miss Chloe Owings, Director of the Bureau of Social Hygiene Research of the University of Minnesota, presented a very interesting account of a specific piece of research her bureau is carrying on with a selected group of parents in Minneapolis. As a result of this work the bureau already has five or six studies in the process of construction, which may serve as a valuable guide in the preparation of personal instruction in sex education for the use of parents.

Mr. Charles Minor, Superintendent of the Committee of Fifteen of Chicago, and Dr. Parran, Assistant Surgeon General of the United States Public Health Service, directed their remarks to the social worker and the nurse. Each speaker emphasized the need of a more constructive attitude on the part of the nurse and the social worker toward both the educational and medical aspects of the social hygiene program. Dr. Parran stressed the need for individualization in venereal disease control and the unique position of the nurse in such an approach. Mr. Minor said that the progress of social hygiene in the next five years would be significantly influenced by the participation of the social worker, including the nurse.

Dr. Valeria Parker of the American Social Hygiene Association, with her very wholesome view of the youth of today, indicated the frankness of the youth of today as a definite opportunity for understanding his needs. Mr. Galloway, also of the National Association, treated the subject from the viewpoint of the teacher interested in formulating a plan of group instruction in sex hygiene for the junior high school student. The arguments were so logical and sound it was indeed a challenge to any teacher of biology.

A look into the future of social hygiene as presented by Rev. Anna Garlin Spencer of Columbia University showed that practical lines of concentrated effort should be directed toward recreation, leadership and family relations counsel in the work of social hygiene.

Legal, medical and educational needs as related to social hygiene all took their rightful place on the program. The need for closer coöperation of all social agencies and other individuals interested in the betterment of society stood out as a responsibility requiring careful thought, and one to which we as nurses must give constructive attention.

CLARA B. RUE

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

COMMITTEE APPOINTMENTS

The Board of Directors of the N.O.P.H.N. appointed the following committees at the September meeting to serve for the next biennial period:

FINANCE COMMITTEE

Mrs. John A. Haskell, *Chairman*
Mrs. Frederick M. Alger
Mrs. John W. Blodgett
Mr. Raymond Clapp
Mr. Michael M. Davis
Mrs. John W. Satterfield
Two to be appointed

NOMINATING COMMITTEE

Theresa Kraker, *Chairman*
Naomi Deutsch
I. Malinde Havey
Mrs. Kathryn Schulken
Mrs. Elsbeth Vaughan

ELIGIBILITY COMMITTEE

Gertrude E. Hodgman, *Chairman*
Nina D. Gage
Ruth Houlton
Abbie Roberts

EDUCATION COMMITTEE

Katharine Tucker, *Chairman*
Nina D. Gage
Mary S. Gardner
Alma Haupt
Prof. Ira V. Hiscock
Gertrude E. Hodgman
Marion G. Howell
Lillian Hudson
Gertrude Peabody
Marion Rice
Abbie Roberts
Isabelle Stewart
Shirley Titus
Two to be appointed

RECORDS COMMITTEE

Mary A. Brownell, *Chairman*
Ellen Buell
Anna Ewing
Katherine Peirce
Marion Sheahan
Maud Steeves
Mrs. Belle Wagner
Dr. Emma Winslow
One to be appointed

PUBLICATIONS COMMITTEE

*Elizabeth G. Fox, *Chairman*
*Mary Arnold
*Janet M. Geister
Grace L. Holmes
Mrs. W. H. Lee
Mrs. Charles Lockwood
Pearl McIver
*Sophie C. Nelson
Mrs. John Sternhagen
Jessie L. Stevenson
*Emeline Street

COMMITTEE ON AFFILIATED ACTIVITIES

Florence Patterson, *Chairman*
Katharine Faville
One to be appointed

ADVISORY COMMITTEE ON N.O.P.H.N. FIELD STUDIES

Sophie C. Nelson, *Chairman*
Amelia Grant
Theresa Kraker

NURSING RELATIONSHIPS IN COUNTY HEALTH UNITS COMMITTEE

Elizabeth G. Fox, *Chairman*
Ada Taylor Graham
Abbie Roberts

SERVICE EVALUATION COMMITTEE

Dr. Haven Emerson, *Chairman*
Mary S. Gardner
Theresa Kraker
Katharine Tucker
Elizabeth Van Patten
Mrs. Adrian Van Sinderen
Mabelle Welsh

* Executive Section.

As a member of the National Health Council the N.O.P.H.N. welcomes Dr. Kendall Emerson of Worcester, Massachusetts, who has been elected Managing Director of the National Tuberculosis Association. Dr. Emerson brings to the position a long, varied and useful experience in medical, social, and anti-tuberculosis work. Since 1926 he has been president of the Massachusetts Tuberculosis League and a representative director of the National Tuberculosis Association.

Dr. Linsly R. Williams, Managing Director since 1922, in tendering his resignation, stated that he was loath to leave the work of the Association. He deeply appreciated the support which had been given his administration by the board of directors and the secretaries of the various state and local associations.

Beatrice Short, assistant director, and Dorothy Deming, assistant editor, attended the American Public Health Association and American Child Health Association meetings in Chicago October 15–19. Miss Short also attended the annual meeting of the Massachusetts Association of Directors of Public Health Nursing Organizations in Boston on October 24.

Marjory Stimson, assistant director, spoke at the Board Members Institute held in Elizabeth, New Jersey, October 23.

Mrs. Violet Hodgson, assistant director, spoke at the meeting of the Massachusetts State Graduate Nurses' Association in Boston, October 24.

Five staff members attended the New York State Nurses' Association meetings in Brooklyn.

The National Society for the Prevention of Blindness will hold its annual meeting in New York City November 26–28. A joint session with the American Association of Industrial Physicians and Surgeons will be held November 26, and a joint session of the Society and the National Organization for Public Health Nursing November 27. Many of the sightsaving class teachers and supervisors in the United States are expected to be present at another joint meeting with the Society.

The attention of our readers is called to the announcement of special magazine offers on page 192 of the advertising section. We are particularly glad to offer a combination subscription of this magazine with the *American Journal of Nursing* at $4.50 a year.

International Golden Rule Sunday is December 2nd. This is probably the last time that Near East Relief will share in Golden Rule Sunday funds. The organization's commitments toward the more than 30,000 boys and girls still in its care include the upkeep of hospitals and clinics, schools that train for deaf-mutes and the blind, and vocational schools that train for self-support. Expenses have been budgeted at $6,000,000. The Golden Rule Sunday observance will help to provide this essential amount.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER
Vice-President, Instructive Visiting Nurse Society, Washington, D. C.

METHODS OF PUBLICITY IN VISITING NURSE ASSOCIATIONS

After reading the following accounts, we hope that any association doing original publicity work will be generous enough to pass on its experience to other associations by communicating with the editor of this department.

Raising Money

As our Association receives support from the Community Chest, we carry on no publicity for raising funds. During the Chest campaign we have been asked to provide tableaux for meetings, to prepare window exhibits, etc.

We have recently mailed to a selected list a pamphlet copied after the annual report of the Omaha Association, calling attention to memorial nurses. During the next twelve months different information in regard to the Association's work is to be sent quarterly to this same list.

Popularization of Work

Our program of publicity on health subjects is educational in purpose but may popularize our work.

Several times a year we distribute to factories, schools, social agencies and public buildings, 85,000 leaflets and 1,500 posters, with posters also displayed in street cars, on such subjects as tuberculosis, cancer, heart disease, the Summer-Round-up of children, etc.

We have advertised the hourly nursing service by mailing our folder "Nursing Service for Every Home" or blotters, to ministers, physicians, school principals, presidents of clubs and parent teacher associations.

All prenatal, baby welfare, preschool and tuberculosis patients are mailed instructive pamphlets; leaflets on breast feeding and an attractive baby record, with a letter to parents, are enclosed in the birth certificates delivered by our nurses.

General Publicity

After each board meeting, accounts of the reports given and of the month's work are published in the daily papers. Occasionally a reporter goes with a nurse to certain cases, where publicity would not be harmful, no names being mentioned. We consider our annual report a form of publicity.—*Toledo District Nurse Association.*

Raising Money

During the annual fall campaigns of the Community Chest we contribute window exhibits, sometimes with a living demonstration of our work at certain hours of the day, which are fairly satisfactory. In our 15 health stations with a total of 4,518 cases registered, we endeavor to interest the mothers by special posters, telling them that this is the time of the year when they can give all their interest along the line of publicity for money raising. In our exhibits we endeavor to contribute something new each year, not, however, changing the entire exhibit. For instance, one year we exhibited three types of homes, showing the interior by cutouts. One was a tenement house, in which a maternity case was cared for; another, an attractive cottage, on the porch of which a tuberculosis patient was being cared for by the nurse; third, a shack in which the nurse was taking care of a pneumonia case. Last year we had an electric flashing exhibit, which depicted the five types of service we render.

Popularization of Work

In most communities the work of the visiting nurse association is perhaps more popular than any other social agency because it is tangible, easily visualized and appreciated. The fact that our work has grown by leaps and bounds during the past six years we feel is due largely to the public who have been helped and have spread the good news to their neighborhood, friends, and relatives, and also to the personal contact made by the nurse in the home.

General Publicity

We feel strongly that *every day publicity* assists greatly not only in raising money but in popularizing the work. The first and most important agent is the nurse in the field. Whatever type of public health work the nurses do or what kind of a patient they are with, they give all the information possible about the work of the association and outline the services and what they mean to the community. They also leave what we call a small visiting card, 5" x 3", telling (1) what our services are, (2) where the health stations are and the day and hour of the conferences for the babies and pre-school children, (3) the clinics. On the back of this card is outlined the cost of service with an additional remark concerning contributions.

The monthly report is always discussed in the newspapers. The educational work, or any special feature we have, is announced and remarked upon. We have a monthly mimeographed bulletin for the purpose of presenting some of the interesting details of the daily routine. Copies are sent out every month to the board members and interested friends.

Last December we published a very attractive Christmas greeting folder with a list of ten "Do you Knows?" concerning the services which we render the community. These were sent out to all of the doctors and many contributing friends. In empty store windows in different parts of the city we exhibit posters throughout the year. These exhibits are not only educational but keep the work of the Visiting Nurse Association constantly before the public.—*Visiting Nurse Association of Hartford, Conn.*

Our funds are raised by means of a Community Chest, which the last few years, unfortunately, has not reached its goal, so that we have been obliged to accept a cut. In order to make up the deficit, we have this year raised over a thousand dollars by having a large bridge party. Through a series of newspaper articles (written by a board member) discussing the serious curtailment of some branches of the work through lack of funds, quoting typical cases, several hundreds of dollars were voluntarily contributed.

We believe that the nurses themselves are the best publicity agents, as each nurse is so well known in her particular district. Her coöperation with the doctors, both in her work for his patients and at the clinics, is also a means of publicity.

We have mailed a copy of our Annual Report to everyone on our mailing list, about 500. We intended to follow this by other pamphlets at regular intervals, each featuring some phase of public health work, with short explanatory statements. This program had to be given up, much to our regret, as we believe this method of publicity is a good one to acquaint people with the work being done in their own city.

Our big publicity event of the year was a lecture given by Prof. C.-E. A. Winslow on "Public Health Nursing—What It Is and What It Means to the Community." This was an open meeting, all the doctors, dentists, city officials, nurses' associations, clubs, etc., having been specially invited. We felt that it was worth while, and a valuable piece of educational propaganda.—*Brockton, Mass., Visiting Nurse Association.*

(*To be continued*)

Communications for this department should be sent to Mrs. G. Brown Miller, care of THE PUBLIC HEALTH NURSE, *370 Seventh Avenue, New York City.*

REVIEWS AND BOOK NOTES

Edited by DOROTHY DEMING

A special study of the *Interrelations of the Hospital Social Service Departments and the Community Health Association* has just been completed in Boston. This study was made by Mrs. Elizabeth Richards Day, who started the social service department at the Boston Dispensary, married Dr. Hilbert Day, raised a family, and now after several years returns to social work. This study therefore represents the point of view of one once extremely close to the problem, who has returned with an entirely fresh point of view. Copies of the report are available at 25 cents apiece. While many of the findings and recommendations of the study only apply locally, others are of universal interest.

Among the notable recommendations are:

That a group representing the hospital social service departments and the Community Health Association meet to work out a uniform policy and procedure for interchange of services such as referring and receiving reports of patients, exchange of medical information, nursing orders, the type and permanence of records to be used for referred patients.

That mutual effort be made to understand one another's purposes, organization, methods, problems and personnel.

That there be added to the training of students in the School of Public Health Nursing and the School of Social Work a period of observation in one or more social service departments and a correspondingly carefully planned program of observation at the Community Health Association.

That a release of supervisors from the Community Health Association be arranged for experience with the social service departments.

That the possibility be considered of appointing to the staff of the Community Health Association a social case worker to bear to the staff and outside agencies a relationship somewhat similar to that now held by the other special supervisors.

In a recent publication—*Convalescence, Historical and Practical,* by John Bryant, M.D., published by the Sturgis Fund of the Burke Foundation, New York—it is stated that 25 per cent of the patients admitted to the Burke Foundation country convalescent homes are chronic. Quoting from an address by Dr. Frederic Brush on The Interrelation of Chronic and Convalescent Care, given in Detroit in 1927:

"There is a neglected intermediate section in our public health, comprising in bare outline the chronics, cripples, moderate defectives, the half-sick, reconstruction cases, preventives of many kinds, and the variously handicapped. The borders of this grouping may not be precisely defined, but it is getting recognized as a dark zone on our health and industrial charts—a reproach and a challenge. Aggregate millions of our population are in this classification." . . . "They are the most difficult to diagnose, treat and adjust in life. The majority of physicians touch more or less casually or evade their problems. A body of workers, mainly non-medical, is slowly developing for their relief; social workers, reconstructional aides, agencies and schools for the handicapped, vocational guidance and special employment bureaus, visiting nurse associations, improved general and special clinics, convalescent homes, and better coördinating welfare organizations.

How long can the medical profession measurably ignore this responsibility and opportunity? Prevention, the treatment of acute illness, and sanitation are well forward; this subnormal zone, in which charlatanry and maladjustment flourish, awaits further entry.

Convalescent building costs per bed are now only about one-third that of hospital construction, with a like low ratio for equipping and for daily per capita maintenance. . . ."

All nurses, whatever their specialized field, will be interested in the new publications which have been prepared

through the headquarters of the American Nurses' Association, 370 Seventh Avenue, New York City. *The Digest of Laws of the States Requiring Registration for Nurses and Attendants* has undergone its 1928 revision and the A.N.A. once more is indebted to Mrs. Lucile McCarthy for her part in this arduous task and to the Wisconsin Legislative Library which made it possible for her to undertake it. (Price 50 cents.)

A List of Schools of Nursing Accredited by the State Boards of Nurse Examiners is nearing the completion of its biennial revision and is on sale, price $1.50. The *Proceedings of the 26th Convention of the American Nurses' Association* are also available now ($.75).

There are a number of new and valuable reprints, among the latter being the following papers presented at the recent convention:

The American Nurses' Association Today—S. Lillian Clayton
Tuberculosis Among Young Women—Jessamine S. Whitney
Tuberculin Hypersensitiveness and Tuberculous Disease Among Nurses—Drs. Sidney J. Shipman and Elizabeth A. Davis
What the Registry Means to the Private Duty Nurse—Emma L. Collins
What Well Organized Floor Duty Offers to the Private Duty Nurse—Frances Courtney

Reprints vary in price from 10 to 25 cents.

One may now purchase from the National League of Nursing Education, 370 Seventh Avenue, copies of Miss Nutting's book, *A Sound Economic Basis for Schools of Nursing, and other addresses* ($2.50). Into this volume is gathered the harvest of wide and wise experience. It is a book worth quoting.

The League is also selling photographs which would make appropriate gifts for nursing offices, board members, executives, or prizes for nursing contests.

Florence Nightingale
Linda Richards
Isabel Hampton Robb
M. Adelaide Nutting
Sophia T. Palmer
Jane A. Delano

Prices range from $1.00 to $16.00. A leaflet illustrating the photographs and giving prices will be sent upon request.

A reprint from *Hospital Social Service* entitled *The Social Service Exchange—Its Place in Modern Social Work* by Arthur Dunham, may be purchased from the author, 145 Hilldale Road, Lansdowne, Pa., for 20 cents. This is a simple presentation of what every social worker should know about the use of the Social Service Exchange. It is the only general pamphlet on the subject now in print.

It is occasionally a graduate nurse's unfortunate lot to have to repeat state board examinations for registration in a state in which she wishes to practice, or to secure a civil service appointment. As a short cut review of her subjects she will find *Answers to Questions Prescribed by Nurses' State Boards* by Robert B. Ludy, M.D., very helpful. David McKay Company, Philadelphia.

Outdoor Recreation for Employees, Report No. 76 of the Policyholders Service Bureau, Metropolitan Life Insurance Company, suggests several forms of recreation which are practicable for employees of large and small industries. Industrial nurses who may be anxious to encourage outdoor noon hours will find this report valuable.

A handbook of Standard Methods of the New York State Division of Maternity, Infancy and Child Hygiene is now ready for distribution and may be had on request.

This handbook was prepared for the use of public health nurses, health officers and committee members and describes the detailed ways of organizing, developing and conducting maternity, infancy and child hygiene activities as recommended by the New York State Department of Health.

NEWS NOTES

The seventeenth Annual Meeting of the Canadian Public Health Association was held in Winnipeg October 11–13. The following papers were presented at the Public Health Nursing Section, Miss Jean E. Browne, Chairman:

The Teaching of Health in Normal Schools—Rae Chittick.
The Teaching of Health in Elementary Schools—Elizabeth Russell.
The Teaching of Health in High Schools—E. M. Simpson.
The Teaching of Health in the Home—Edith B. Hurley.

Among the other papers of interest were: A Public Health Nursing Program for a Community of 5,000—Nann McMann, Victorian Order of Nurses; Group Instruction of Mothers in the Health Center—Edith Fenton, Dalhousie Health Center; and a session on County Health Units.

A meeting of representatives of agencies interested in the promotion of the 1929 Negro Health Week was held in Washington October 30 under the auspices of the U. S. Public Health Service. The subjects considered were:

The Health Week Bulletin
Suggestions for improving health conditions among negroes in rural communities, and in urban centers.

Mary M. Richardson, formerly instructor of public health nursing at the Providence District Nursing Association, has returned from a year's work in England, where she has been studying midwifery at the British Hospital for Mothers and Babies, Woolwich, London. After passing the examination of the Central Midwives Board last May, Miss Richardson made an extended tour of England, Holland, Belgium and France observing the various types of midwifery schools there.

Miss Richardson has just been appointed directress of nurses at the Manhattan Maternity and Dispensary, New York City. A course in midwifery is now being offered at the Manhattan Maternity to public health nurses and nurses contemplating missionary work. Katherine Stiles and Doris Beaumont, the first graduates of the new course, are now on the staff of the Frontier Nursing Service.

Miss Olive Baggallay, who spent nine months in 1925 on a traveling scholarship from the Nightingale School, St. Thomas' Hospital, London, studying the methods of public health nursing in America, and who for the past two years has acted as instructor in public health nursing for the students of the International Nursing Courses organized by the League of Red Cross Societies at Bedford College, London, has recently been appointed to the staff of that college (Department of Social Studies and Economics), as tutor to the students in connection with the practical side of their training. This practical work will be carried out mainly under the auspices of the Social Service Department of St. Thomas's Hospital, where Miss Baggallay holds an appointment in the tuberculosis section and where she will be in close touch with other departments doing preventive work.

Miss Baggallay's duties will include the organization of other centers of practical training. She will also give lectures on public health nursing in the Department of Social Studies and Economics at Bedford College.

Miss Baggallay is the first nurse to receive an appointment of this kind on the staff of a college in the University of London. In order to enable Miss Baggallay to study health and nursing organization in Belgium, France, Austria and Czechoslovakia, a six weeks' traveling scholarship was recently awarded her by the League of Red Cross Societies.

Elena Crough Lockwood, formerly Director of Division of Child Hygiene and State Advisory Nurse for New Hampshire Board of Health, is now with the Children's Bureau, Washington, D. C., on a part time basis as Consultant in Community Organization.

Mildred G. Smith, R.N., Staff Associate, National Society for the Prevention of Blindness, recently visited five colleges in the Middle West which were giving summer courses for public health nurses. Talks were given on the testing of vision of the young child, especially of the preschool and early school groups. Several of the schools which Miss Smith visited plan to include instruction in vision testing of young children, with practice in the field, as part of their regular curricula.

The newest branch of nursing we know of is the British Royal Air Force Nursing Service formed in 1918 as a temporary war measure and later established under Royal Warrant as a permanent nursing service of the Crown. We wonder do they wear wings.

The *North China Herald* announces that a new organization, the National Child Welfare Association of China, has recently been formed under Dr. H. H. Kung, Minister of Industry, Commerce and Labor, with headquarters in Shanghai. It is the outcome of the Canton Child Welfare Committee in which many high officials and merchants and their wives have taken a keen interest. The new association will coöperate with the Association for the Welfare of the Children of China, Inc., which has its headquarters in New York City. The constitution of the new association states that:

> The aim of the Child Welfare Association is to improve the livelihood of poor and homeless children according to the spirit of the Golden Rule.

APPOINTMENTS

Maud Conkling, head nurse in Maternity, Infancy and Child Hygiene work for Nassau County, Mineola, New York.

Beatrice Sibley, community nurse in Richeville, Pa., under the Metropolitan Life Insurance Company.

Leona Wise Ware, Chief Supervising Nurse, Illinois State Department of Public Health, Springfield, Illinois.

Jane Nicholson, Tuberculosis Supervisor for the New York City Department of Health.

The following nurses have been appointed to staff positions in the New York City Department of Health in the Bellevue-Yorkville District: Ellen Bradley, Lida M. Searing, Katherine Krupsaw, Dorothea Loree, Jane McGinley, Margaret Lorne.

Emma Wilson, Kathryn Walsh, Margaret Leavitt, Mary Ennis have been appointed for a special ventilation research project in the New York City schools.

Clara Ross in charge of the public health nursing service in the County Health Department, Spartanburg, S. C.

Mary Pritchard, Director of the Visiting Nurse Association at Bellingham, Washington.

Candace Seeley, Director of the St. Paul Baby Welfare Association, St. Paul, Minnesota.

Marion Douglas, formerly Nursing Educational Supervisor and Acting Assistant, Executive Office of Bellevue-Yorkville Health Demonstration, as Secretary, Committee on Maternal Care, Children's Welfare Federation, New York City.

STATE MEETINGS

State meetings for November of which we have information are as follows:

Minnesota—November 6–8, St. Paul
Georgia—November 8–10, Columbus
Florida—November 1–3, Tampa

We will be glad to have notices of meetings from other states for publication. Send in the information, with a program if possible, to headquarters before the tenth of the month preceding publication.

The next Wisconsin State Board Examination for Registered Nurses will be given on December 4, 5 and 6, 1928, in the City Hall, Milwaukee, and the Court House, Ashland.